

**INVESTIGATING EGYPTIAN STUDENT
NURSES' PERCEPTION TOWARDS
WORKING IN MENTAL HEALTH NURSING**

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A thesis submitted in partial fulfillment of the
requirements for the degree of professional
Doctorate of health and social sciences
[Nursing]

QUEEN MARGARET UNIVERSITY

2016

Abstract

This research aims to explore Egyptian undergraduate nursing students' perceptions of working with mentally ill patients and to explore factors that influence student nurses' perceptions of mental health nursing. The study took place at the school of nursing in Cairo University.

The research approach for the study is qualitative and descriptive since it aims to explore opinions and perceptions of participants and describe meanings about researched topic (Creswell 2014, Willing 2013, Hancock et al 2009).

The method for data collection used in the study was focus group discussion: 8 focus groups were conducted that included 32 participants, all of them female students. A pilot focus group took place at the faculty of nursing in Modern University for Technology and Information (MTI) where fourth year students were asked to participate. The remaining focus groups were held at the school of nursing in Cairo University. Participants were chosen from fourth and fifth year students of the undergraduate programme. The participants had accumulated knowledge as students and they were about to graduate and to start their nursing career.

Data analysis stage of the study employed thematic analysis to develop codes and themes that constitute the results of the research.

Results of the study revealed that stigma associated with mental health nursing (MHN) is one of the main factors that keep students away from this specialty. Students expressed their fear and lack of a sense of safety within mental health facilities. The main stereotype as expressed by participants was that patients are violent and potentially aggressive. Other factors contributed to a negative view about MHN such as lack of positive role models, insufficient clinical training and the need for clinical supervision within mental health clinical placement. Few participants expressed an opposite opinion and were motivated to work in MHN but were not sure how to start this career. The gender issue appeared to be influencing perception of MHN since many considered MHN as a male job.

Acknowledgment

I would like to thank Dr Lindesay Irvine for her continuous support at different stages of my learning journey and appreciate her positive contribution to my learning. Also I appreciate the help of all supervisory team including Dr Ann Williams and Dr David Banks.

Thanks to the kind help of Professor Cheherazad Gazi and Dr Phyllis Runciman who contributed to the grammar editing of the thesis and provided many references and books from her own library.

I also appreciate the kind help and support from Dr Emad Sidhom who worked as a critical companion at different stages of the research and provided enlightening references and feedback. He also helped in the translation of transcripts and added valuable feedback regarding facilitating focus groups.

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Abbreviation

MH	Mental Health
MHN	Mental Health Nursing
MTI	Modern university for technology and information
G1	Group one
G2	Group two
G3	Group three
G4	Group four
G5	Group five
G6	Group six
G7	Group seven
G8	Group eight
P1	Participant one
P2	Participant two
P3	Participant three
P4	Participant four
P5	Participant five
ECT	Electro convulsive therapy

CHAPTER 1

1.1 INTRODUCTION

During the last 7 years I supervised students being trained at mental health facilities and geriatric care homes in Egypt. The main two noticeable observations, from my work experience, were the ongoing comments from mental health facilities that they needed nurses to work there, and that there is a shortage of health care providers in general within this area of practice. The other observation was the lack of interest from nursing students to work there and their decision to avoid mental health nursing (MHN). The next part will explain why it was important to me as a nurse educator to start this study and the influence of my work experience as a motive for conducting this research.

1.2 Motivation for the study

During the last 7 years of working with university nursing students and with nursing schools' students, I was aware that MHN is not a very popular area when it comes to career choice among a noticeable number of graduates. I was not sure why MHN was unattractive and wished to question the students' perception about this specific field of nursing. From experience, I noticed that although nursing school students had clinical placements at general hospitals, nevertheless they used to avoid communication with patients who seemed to have psychiatric disturbances. On other occasions during the clinical placements some specific mental health situations could not be overlooked and required some analysis. For example, when a patient suffered from a cognitive problem associated with physical illness such as hepatic coma, delirium or Intensive Care Unit (ICU) psychosis, some students expressed their worries and lack of confidence in caring for these patients. The situation was similar with university students who are older and get more clinical experience and theoretical knowledge. On many occasions, university students expressed their lack of interest in starting the training in mental health facilities and it was quite rare to see students choose mental health as

an elective module during the final year. All these signs of avoidance required an exploratory study to be conducted to clarify student nurses' perception about MHN and analyse factors influencing this perception. Another motivation for the study was to clarify the role of education in influencing students' perception of MHN and how this role could positively be activated from the students' viewpoint.

Literature such as Goffman's work notes the issue of stigma that might be evident through avoidance and communication challenge, in relation to people who might not be considered normal or associated with mental disturbances (Goffman 1963). Also Schumacher et al (2003) point to the stress and anxiety among nursing students that could be associated with clinical placement within the field of psychiatric nursing. Yet, I could not assume that stigma is the main influence that affects nursing students' practice within MHN in Egypt or that students nurses' perception would be associated with fear. The qualitative research of Moagi and Martiz (2013) revealed a different positive side of students' perception of MHN, related to the support within clinical placement and the effect of connectedness between theory and clinical practice in MHN on formulating students' experiences. The students described MHN as a life changing experience and valued the role of nursing staff and clinical environment as playing a significant role in their perception of MHN (Moagi and Martiz 2013). Their study, conducted in south Africa, shows that perceptions about MHN are not always connected with stigma and negativity, and it reveals the importance of students' feedback and experiences to present clear understanding about a specific field of nursing.

Therefore, this current study aims to explore student nurse' perceptions of MHN without making any prior assumptions. The study is specifically important in the context of constant shortage of MHN workforce in Egypt (WHO 2006). The results of the study could lead to highlighting factors affecting future nurses' perceptions regarding MHN and reveal significant data regarding enhancing psychiatric nursing in Egypt. The scarcity of data regarding nurses' perceptions of MHN in Egypt was another motive to start this exploratory descriptive study.

1.3 Background and context for the work

Attending the weekly case presentations at a private psychiatric hospital in Cairo during the last three years enabled me to witness several situations concerning patients with mental health issues. One of these situations came up during the morning case studies when a psychiatric consultant described how one of his patients went to an outpatient clinic suffering from severe headache. The general practitioner checked the file and knowing that the patient was suffering from a mental health problem he advised the patient to return to his own psychiatrist for treatment of his symptoms. The patient returned to his psychiatrist suffering from severe headache and loss of concentration. Examination revealed that the patient's blood pressure was over 180/110 mm/Hg at that time and he was transferred to emergency care. The consultant described this situation to remind doctors that in some cases mental patients' complaints are simply ignored and merely attributed to their mental illness even if the problem is physical. The consultant defined the doctor's perception of patients as "once psychiatric...always psychiatric", a stereotype common among some doctors in Egypt.

The second situation came from another psychiatric consultant who worked in the field for more than 40 years and has extensive experience in mental health care in different countries in the Arab world. The consultant's presentation was about society's perception of depression and how society in Qatar, Egypt and Kuwait - where he used to work - stigmatises depression. He described the struggle that depressed patients go through, and the pressure exerted over patients to turn to religion as a way to fight depression. Yet, he mentioned three incidents of Muslim clerks and Imams who committed suicide inside their own mosques. The consultant was trying to expose the true face of depression and reveal the amount of pressure, blame and lack of empathy that patients suffer from. He tried to emphasise the fact that having more religious practice has nothing to do with the treatment of depression.

The exposure to different situations through case presentations showed how the Egyptian society, sometimes including physicians, perceives mental

health problems differently. The importance of starting to investigate the issue of nurses' perceptions of MHN, in an attempt to reach conclusions that might help in enhancing nursing education and enriching students' learning experience in this area, is evident. The fact that nurses, including student nurses, may meet patients who might suffer from psychiatric problems in all hospital wards, leads to the conclusion that knowing about mental illness is a must for nurses working in Egypt. The researcher believes that improving perceptions of mental illness and confronting stereotypes is an integral part of a nursing educator's responsibilities.

1.4 Significance and Potential Contribution of the Study

A clear understanding of the students' perception of MHN is important as it might indicate why nurses do not choose to work in this field. The study has potential to enhance mental health nursing education and will be used to address students' concerns within the curriculum. Students' perceptions of MHN will also reflect the societal perception, and this study may highlight factors that influence this perception.

Nursing in Egypt

Nursing graduates in Egypt are either secondary school diploma nurses who graduate after 5 years of study. These diploma programmes are a non-university based programmes. The other level of nursing graduates is the university based nursing programmes or the bachelor of nursing programmes. Graduates of bachelor level nursing education are seen to be in a higher level of education and study for 4 years after secondary school (Boggatz 2011). Within both levels of nursing, graduates become general nurses, as there is no specialty level of nursing in the Egyptian nursing system and there are no specialized courses to qualify nurses to work in a specific area of practice. So, nurses choose their specialty after graduation, according to their preferences, without specialized training and learn about this specialty during work in the field. Consequently, in case a nurse preferred to work as a psychiatric nurse, it is her own responsibility to find a place that will recruit her and train her to

be able to work in the field of mental health nursing if she does not have previous experience in this area of practice. It is not clear whether nursing graduates are considering mental health as one of the specialties they wish to work at or not and whether this specialty is popular among student nurses or not. It is expected from this research to answer such questions and draw a clear picture of nurses' perception to MHN.

Nursing career is one of the vital jobs in Egypt, yet, it is sometimes perceived negatively by many in Egypt who struggle with cultural barriers as explained by (Boggatz 2011, Fullerton and Sukkary-Stolba 1995). Some of these barriers could be related to gender issues such as nursing a male patient by a female nurse and other factors could be underpayment of nursing workforce and the low wages of nurses in Egypt at both governmental and private sector (Baggatz 2011). The literature review will discuss in depth the factors influencing perception of mental health nursing and explore whether nursing image and attitude towards nursing would be a factor that affects mental health nursing or not.

CHAPTER 2

Literature review

2.1 Introduction

This review of literature covers different aspects related to perception of mental illness. One of these aspects is the historical background of mental illness and the way Egyptian society perceives it. The effect of culture on addressing mental health problems will be explored with respect to its influence on how patients suffering from mental illness are perceived.

A significant concept found from reviewing the literature and strongly connected with mental illness is “stigma”. Therefore, a separate section on stigma and its effect on how patients suffering from mental problems are perceived is included in the review.

The aim of the literature review is to provide a comprehensive understanding of different aspects associated with mental illness and to explore whether nurses’ perceptions of MHN have been studied before in Egypt. It was evident that documentation, related to Egyptian nurses’ perceptions of MHN, is scarce. This review also enabled the researcher to gain insight about the different factors that influence society’s interaction with patients. The review was also important in identifying and developing a realistic question guide to be used for the focus group interview.

The review has been guided by the following keywords:

Mental illness, perception, conceptions, perspectives, psychiatric nursing, stigma, Arabic culture, Middle East, Egypt, experience, beliefs, attitudes, opinion, mental health nursing, and stereotype.

Finally translations of some Arabic documents were used such as the Arab version of Michel Foucault’s writing on Madness and Civilization available online (Foucault 1972).

2.2 Mental health nursing in Egypt: Country profile

The researcher observed shortage of staff in mental health facilities within her own work environment. To report about the shortage, a review of the literature on nursing statistics and the country profile were important. Reports from the World Health Organization (WHO) refer to the shortcomings of mental health services in Egypt and identify shortage of staff and particularly shortage of nurses to be the top problems of mental health in the country, specifying that there were only two psychiatric nurses and one psychiatrist for every 100.000 citizens (WHO 2006, 2010). This severe shortage, evident in the researcher's experience, is a country wide problem and especially in upper Egypt (World Bank 2015). This shortage requires an exploration of the current perceptions about working in mental health and an in-depth investigation of factors that could lead to the reluctance to work in this field.

Nurses are part of the society and they are not isolated from the society's beliefs, attitudes, habits and historical background. Understanding nurses' perception towards mental health nursing (MHN) in Egypt could be seen as strongly connected with the Egyptian society's perception of mental health and illness. The first section of literature will provide a historical background for mental illness in the Egyptian society and will be followed by an exploration of the current MH situation in Egypt.

2.3 Mental Illness Through History

Mental illness has been acknowledged in the Egyptian history since the Pharaonic era as documented in papyri, yet it was attributed to changes in the uterus and heart and was treated by physicians and priests (Okasha 2005, King 1999). During Pharaonic time, there was no separation between mind and body and most psychiatric symptoms were addressed through religious practices and dealt with through prayers by temple priests (Okasha 2005). Throughout the Islamic era in the 14th-century, the first hospital that accommodated a specialised section for mental illness was established at the heart of Cairo by Sultan Al Mansour Kalaoon and was called Kalaoon hospital (Okasha 2001). The Egyptian society's perception of mental illness was strongly connected to religion as some illnesses were referred to as

possession by demons, being away from God or being a non-believer (Okasha 2001). During that time, patients were treated with respect and were not subjected to torture or oppression (Okasha 2001). Patients suffering from mental disturbances used to be perceived differently according to the level of enlightenment at that time. Caring for patients at that time was left to society and the patient's family (Okasha 2001).

In modern history, Abdel Aziz (2015) differentiated between two stages in the relationship with mentally ill patients and the society in Egypt - before and after the British colonization of Egypt. Before the British colonization, psychiatric patients lived among people in their own community. Egyptians usually perceived them as blessed persons and used to provide them with food and money (Abdel Alziz 2015, Coker 2005). The perception of mentally disabled and mentally disturbed persons as blessed was very common in Egypt, both in Cairo and the countryside (Abdel Alziz 2015, Coker 2005). The situation changed after the British colonisation when the idea of psychiatric asylum and treatment for psychiatric patients emerged. It was decided to build an asylum for patients with mental illness in a calm area away from the heart of Cairo, at Abbasiya. The hospital consequently was called Abbasiya hospital and is still the mother hospital for all mental health facilities in Egypt. The hospital, inaugurated in 1883, required doctors and the health team to live inside the hospital. This seemed to represent a kind of isolation for patients and their health care team away from society (Abdel Alziz 2015).

The indication of isolating patients who suffer from mental disturbances appeared earlier in history as clarified by Michel Foucault who described the situation from a Western perspective during the 16th and 17th centuries. The idea of isolating patients was accompanied by some philosophical views by society who considered themselves as "normal " and considered patients as "the others" (Goffman 1963, Foucault 1972). This concept was connected to the avoidance of fear and stigma and was manifested by measures such as the ship of the insane that was used as a method to get rid of patients and transfer them from one city to another (Goffman 1963, Foucault 1972). Mental health institutions represented another method of isolation to keep patients

away from society. These institutions started at the same places where leprosy patients had been kept away from the city (Foucault 1972). This isolation suggests that it was not easy to accept patients with mental illness within the society. It was evident that stigma also extended to health care providers who worked with such patients (Goffman 1963, Foucault 1972).

Returning to the Egyptian perspective, during the early years of the Abbasiya hospital in Cairo at the beginning of last century, evidence referring to the dangerous behavior of patients suffering from mental illness was detected. Examples are given in the reports of Dr John Warnock, the first medical director of the Abbasiya hospital. Dr Warnock, between 1907 to 1909 stated in his reports to the Egyptian government that many patients at Abbasiya hospital committed suicide, murder and violent activities after their discharge from the hospital. He highlighted an alarming sign about how dangerous patients were, and asked for review of the discharge policy (Warnock 1909). The language used in Dr. Warnock's reports included words such as "Lunatics, Insane and unfortunates" to describe the patients. This language could be seen as humiliating and degrading to patients. But such language would also reflect the cultural perspective of this period. Reading Dr. Warnock's reports uncovers the relationship, at that time, between aggression, violence, isolation and patients suffering from mental illness. There was no Mental Health Act at that time and the policy regarding patients' detention was unclear. Previous factors and incidents might reflect on the society's perception of patients at the early years of the nineteenth century. Other examples from history that clarify the perception of Western society to mental disturbances were identified by Foucault, who described patients to be under oppression and long undignified detention between the walls of psychiatric institutions (Foucault 1972). Although Foucault was describing earlier periods of history, he emphasized the approach of the society to protect its harmony, by excluding others who are different, even if they were under the supervision of religious bodies (Foucault 1972). However, society's beliefs and reactions to patients who are suffering from mental illness are integral factors that shape health care providers' attitudes towards those patients (Foster et al 2008). This literature was helpful to understand the

current situation in Egypt and factors influencing nurses' perception of mental illness and MHN as a career.

Further evidence that supports the depressing picture about mental illness in Egypt was the title of Abbasiya hospital at that time; it was "Abbasiya hospital for the insane". Such terminology about the mental health (MH) field might reflect Egyptian society's perception of mental illness, more than a hundred years ago. According to Viney (2011), Abbasiya old asylum is partly responsible for the negative reputation of mental illness among Egyptians because neglect, abuse, aggression were common. Viney (2011) added that the Egyptian Ministry of Interior had a 'Lunacy Department' that was responsible for psychiatric patients until 1940 when the situation changed to be in the hands of the Ministry of Health. Furthermore, Viney (2011) stated that the new health legislation regarding mental patients considered patients' rights and freedom more than the old legislation yet, time and awareness is still required for the Egyptian society to change. Mourad (2014) criticised the Egyptian society and government for not being supportive enough to mental patients at Abbasiya. Although generalisation about Egyptian society's perception of mental illness should be avoided, Mourad (2014) explains that mental illness is perceived as a stigma in Egypt and this stigma extends to those who work with mental health patients. Overall however, research evidence regarding how nurses perceive working in these mental health facilities is limited.

Okasha (2001) identified that a main challenge regarding MH in Egypt is that it is not considered one of the health priorities. This is because Egypt faces more challenging problems such as birth control, children's health, infections and drug abuse. Further to this Okasha (2001) notes that there is lack of basic services regarding MH such as follow up programmes, rehabilitation centres, and psychiatric hospitals: this contributes to lack of understanding of MH. From another perspective, EL-Islam (2008) presented a detailed literature review regarding Arab communities' perception to mental illness. EL-Islam (2008) concluded that although more acceptance is developing nowadays, still mental illness is associated with social shame, refusal and

stigma for the whole family. However, it is not clear if this stigma reflects on nursing and the care team who work with patients. This issue will be addressed in the research.

Currently, after more than a hundred years, Abbasiya hospital is still one of the main MH facilities in Egypt, and is called Abbasiya Hospital for Mental Health. In a press article by Mourad (2014), the journalist met patients inside the hospital and gave them the chance to voice their opinions about their perception of living with mental illness in Egypt. Although this is not a research article, it is one of the very few writings derived from live interviews with Abbasiya residents (patients) thus presenting multiple views of patients in an objectively written article. In this article some patients who spent long years at Abbasiya reflected that it is becoming easier to talk about mental illness nowadays; but still the issue of public rejection in Egypt is a main challenge. Patients described living outside the hospital to be extremely difficult and stressful because many families break contact with the ill person, change their address, literally abandoning the person for the fear of stigma. Patients complained about doctors' shortage, insufficient financial resources for the hospital, lack of facilities and bureaucracy. Some patients also expressed their need for more compassionate nursing care and referred to the problem of nursing shortage and the need for more educational preparation for nurses to be able to work in this field (Mourad 2014).

The previous section presented mental illness along the different eras in Egypt and the next section will discuss in details the Egyptian society's perception of mental illness. Reviewing society's perception of mental illness is an essential part of the study since nurses are part of the society and it will be important to discover whether society's beliefs are mirrored in nurses.

2.4 Egyptian society's perception of mental illness: hiding mental health problems

Culture affects how people interact, translate life events and respond to problems (Haboush and Alyan 2013, Berger and Luckman 1991). It is important to understand Arabic culture in order to understand mental health

problems since cultural beliefs affect how people seek help for mental health issues and how mental health problems are addressed (Haboush and Alyan 2013). Therefore, in this study it is crucial to draw on the perceptions of mental illness in Arabic culture in order to establish the realistic context for the interviews with nurses in the study. Hence, the following section will illustrate the effect of Arabic culture on perceiving mental health problems specifically from an Egyptian perspective.

Personal experience and literature suggests an overarching cultural perception among Egyptian society towards mental illness, which has been associated with superstitions and evil eye, and influenced by superstitious thinking among both Muslims and Christians (EL-ISLAM 2008). In the Arabic culture, religion is a main issue that impacts on how people interact and perceive life situations (Haboush and Alyan 2013). For example, there is a recognized practice inside the Egyptian Coptic Orthodox Church called exorcism where special congregations are held weekly to fight demonic possession. Many attend this weekly congregation including Christians and Muslims. However, testimonials of participants in these congregations do not address the validity and reliability of this kind of practice. Hence, there is lack of scientific evidence regarding the effectiveness of such practices.

Escaping from psychological stressors and mental problems to the Quran, to prayers, and to Imam (Muslim clergy) and priest consultation are some coping mechanisms to deal with stressors and life challenges (El-Feky 2015, Sabry and Vohra 2013). Many seek these forms of religious practice as a way to address psychiatric problems (Sabry and Vohra 2013). Some consider it a kind of exploitation, illusion and deception for patients who usually do not improve or even get worse (El-Feky 2015). Others argue that prayers and healing with the Quran is helpful for many and sometimes brings positive outcomes (Sabry and Vohra 2013). Yet, Sabry and Vohra (2013) depended mainly on reviewing literature and their work has a limited evidence base and value. It could be suggested that religious leaders in an Arabic society have a superior position that leads people to search for psychological safety from them. Yet this interpretation does not represent the whole picture of an Arabic

society's perception of psychological problems and stressors since many do not rely on religious solutions as a first choice for help with mental health problems (Haboush and Alyan 2013). However, as the researcher in this current study was not sure whether these religious interpretations and management of mental illness would be an aspect of nurses' perception to MHN, it was a possible area to explore in the study.

Fleeing to religious practice could be one mechanism to avoid the stigma associated with mental illness in an Arabic culture. Stigma of mental illness is a main cause that stops some persons from seeking medical advice, prevents them adhering to a treatment regimen, and widens the social distance between patients and the community (Sewilam et al 2015, Fitzpatrick 2015, Zubair 2015, Sidhom et al 2014, Coker 2005). Therefore, searching for less stigmatising pathological reasons to address psychiatric problems other than a diagnosis of mental illness is a way out from the stigma since it is perceived, by some patients' families, as being less stigmatising than going to a psychiatrist (Sidhom et al 2014). In a quantitative study Sidhom et al (2014) explored Egyptian patients (n=109) perspectives on mental illness in a private hospital in Cairo; 89% of patients expressed that they need faith and that traditional healings would help. Also 81% of the patients expressed that they were urged by their families to consult religious clergy for their disorders even before seeking medical help (Sidhom et al 2014). This research, which used structured interviews with 109 patients in a private hospital, not only reflects the degradation of patients suffering from mental illness, but also shows how the Arab society puts more pressure on these patients to be more religious and faithful to God so as to be cured from their symptoms (Sidhom et al 2014). Many patients, both Muslims and Christians, voiced that they were under pressure to stay away from psychiatrists and seek faith and the advice of clergy. Patients in the research said that having a diagnosis of psychiatric symptoms is not a label or a significant problem, yet, they face real stigma when they lose friends and connections with their close society due to their illness (Sidhom et al 2014). The view of patients from previous research raises a current concern for this planned research; that is, whether nurses would respond differently than their society to the stigma of mental illness. If

the society avoids people with mental illness, as expressed in Sidhom et al's study (2014), one can question whether nurses would do the opposite. A further consideration to address is how nurses perceive their work with patients suffering from mental illness in psychiatric facilities, or when they meet them at general hospitals. The current study plans to explore perceptions of nurses' about MHN to inform further developments that enhance nursing education.

Other beliefs about mental health and illness are related to the interpretation of the religion itself among the Egyptian society in both Islam and Christian teachings. Sabry and Vohra (2013) explored many examples from the Quran that depression should be fought and that suicide is prohibited. For example, Sabry and Vohra (2013) stated that verses of the Quran advise to keep hope and avoid hopelessness such as *"And never give up hope of Allah's soothing Mercy: truly no one despairs of Allah's soothing Mercy, except those who have no faith."* (Quran, 12:87). Hence, depression is sometimes perceived as lack of faith. Many Muslims know that the previous sentence reflects a specific occasion in a specific incidence with one of the Prophets; yet, many usually see it as a general principle. Therefore, some mental health problems such as depression and suicide might relate to stigma and shame to the patients and their family since they are culturally associated with lack of faith. The Christian view is similar, where suicide is considered a sin and people should seek help and support from God to give them strength; "Everyone who calls on the name of the Lord will be saved" (Romans 10:13), "My times are in your hands" (Psalm 31:15).

Consequently, it is usual in an Arab country to find that a patient who is suffering from depression and other psychological problems seeks help from physicians for somatic symptoms such as chest pain and headache. These somatic symptoms might encapsulate the psychological distress and mask it to avoid being accused of lack of faith or being a weak person (El-Islam, 1990). In another similar article, El-Islam (2002) called it "the culture of aching heart" or depressive heartache where patients particularly women cannot voice psychological distress. Somatisation is one of the means of

representing psychological problems where it is more accepted and less stigmatising from an Arabic culture perspective (Haboush and Alyan 2013, Al-Krenawi & Graham, 2000).

In summary, some patients might experience accusation rather than sympathy, and blame rather than compassion and understanding when suffering from mental illness. This might reflect the views of caregivers who are dealing with patients. However, there is lack of knowledge whether such beliefs of the society affect student nurses' perception of working in mental health nursing. Hence, exploring perceptions of student nurses has the potential to reveal significant information that might influence Mental Health Nursing (MHN) education in future.

2.5 Nurses' perceptions to mental health nursing

Nurses' perceptions to mental illness and mental health nursing vary widely worldwide. Psychiatric nursing is not considered one of the favored specialties and can be the least desirable as a specialty for many nurses according to (Cirpili et al 2016, Hunter et al 2014, Happell et al 2014, Happell et al 2008). The Egyptian literature about nurses and student nurses' perception to mental illness and psychiatric nursing is scarce, but the following section will present an exploration of perception to mental illness and mental health nursing from different international studies.

In a study from **USA**, Cirpili et al (2016) investigated nurses' perception to psychiatric nursing through quantitative research using survey as the method for data collection. The aim of the study was to rate different nursing specialties and express perception about psychiatric nursing. The study sample consisted of 124 newly graduated registered nurses. Participants in the study not only expressed psychiatric nursing as the lowest rated specialty but they also strongly emphasised that it is a specialty that is also undervalued by the community. The study not only highlighted nurses' perception to psychiatric nursing, but also revealed that more than 74% of participants expressed their rejection of psychiatric nursing as a career choice. The study identified links between positive clinical experience,

education, and perception to psychiatric nursing. Dissimilar results came from another **American** study conducted by Hunter et al (2014). This quantitative survey explored students' perception to Psychiatric nursing and mental illness in general. The study results showed that participants did not hold a negative perception to mental illness and did not stigmatise it and many participants showed compassion with patients and stressed that mental illness is not the fault of patients. Moreover, most participants valued their clinical learning experience in mental health; yet, none of them would think about mental health nursing as a first career choice or even a second or third choice. Hunter et al (2014) emphasised that further research needs to be done to explore factors that influence nurses' rejection of work in the field of psychiatric nursing and to make recommendations to improve the situation. It can be assumed from Hunter et al (2014) and Cirpili et al (2016) studies that positive or negative perception towards mental health nursing and compassionate feelings and acceptance of patients might not be connected with choosing psychiatric nursing as a career. Therefore, the current study is seeking to develop an in-depth understanding of Egyptian student nurses' perception to mental health nursing.

Regarding families' views about mental illness, Dalky (2012) conducted a literature review to examine families' perception worldwide to mental illness among different communities including different countries of the **Arab** world particularly Jordan and Morocco. Dalky (2012) found very common challenges facing families with a relative who has mental illness. These challenges could be fear, isolation, destruction of family reputation, fewer chances in jobs and marriage and social rejection. The study concluded that although families take the responsibility of caring for a relative who is suffering from mental health problems, more understanding is required of factors influencing stigma and called for more initiatives to face stigma associated with mental illness among patients' families.

Student nurses as part of a wider community might be influenced by community's perceptions and beliefs, holding a negative attitude towards working within mental health field (Tee and Ozcetin 2016). Tee and Ozcetin

(2016) conducted a study in **Turkey** to examine the effect of education on nurses' perception to mental illness. Their qualitative research assessed the effect of a person-centered programme on student nurses' work with patients suffering from mental illnesses. The in-depth semi structured interview with undergraduate nurses showed less fear and more understanding to mental health problems among nurses after studying the designed person-centered programme. Although the sample in their study was only 12 undergraduate students, yet, the results are important to show that perceptions and attitude of nurses towards mental health are not static and can change according to different factors such as education and preparedness. Moreover, Tee and Ozcetin (2016) concluded that educational preparation for undergraduate nurses makes them more positive towards mental health problems and more open to working with patients and experience less feelings of fear.

From another perspective, a quantitative study from **Sweden** by Martensson et al (2014) explained more factors that influence nursing staff attitude and perceptions to patients with mental illnesses. The study was conducted with 256 nurses and revealed that the main factor influencing nurses' perception to mental illness was the "contact"; the more there is contact with patients suffering from mental illness or having a friend or a family member who had mental illness, the more positive attitude is observed and less stigmatisation to illness. Martensson et al (2014) point to other factors that influence staff attitude to mental illness such as the work place, previous knowledge and sociodemographic characteristics. Hence, it can be concluded, that different factors affect nursing staff attitudes to mental illness such as clinical placement, previous knowledge, and previous contact with patients, and sociodemographic factors. However, it is not known yet if Egyptian nurses will raise similar factors within this current study or whether different aspects will be expressed by nursing students in Cairo.

From a **Canadian** study, Tognazzini et al (2008) explored whether mental illness stereotype and stigma would affect nursing practice. Tognazzini et al (2008) stated that society does stigmatise mental illness and nurses do reflect the societal attitude towards mental illness. Furthermore, Tognazzini et al

(2008) confirmed that more educational preparation for nurses is required to enable student nurses to provide effective care in the field of mental health. Tognazzini et al (2008) articulated their concerns about nurses and care providers towards mental health problems. Many situations mentioned in their 2008 paper reveal the lack of understanding or empathy and lowering the priority of mental problems even when the problem is life threatening, such as suicidal tendency. Tognazzini et al (2008) reviewed different Canadian reports and connected a relationship between the nurses' learning experience and career choice. Many Canadian student nurses expressed that MHN is not a favorable area to work in (Tognazzini et al 2008). However, in the current study, we are at an early stage of exploring Egyptian student nurses' opinions about MHN. Results from this study could be used for further research if student nurses express that they are not satisfied with the MH learning experience.

Reed and Fitzgerald (2005) conducted a qualitative descriptive study in **Australia** among nurses in general hospitals exploring their opinion about working with patients suffering from mental illnesses. 50% of nurses expressed some negative feelings such as fear, avoidance and inability to provide competent care to patients with mental illness and linked the reasons behind this to priority level of care. It seemed from nurses' opinions that physical problems are managed before psychiatric problems and usually have priority to be treated first (Reed and Fitzgerald 2005). Also, many participants in the study clarified that the health care environment in general hospitals is not prepared for psychiatric patients. This was a challenging factor affecting nurses' anxiety and patient safety. Experience, knowledge and education seemed to be other factors that affect nurses' perception to working with psychiatric patients. However, some nurses expressed positive perceptions such as acceptance, compassion and enthusiasm for working with psychiatric patients and considered it an integral part of nurses' role (Reed and Fitzgerald 2005). Another positive view came from a study conducted in **Jordan** that aimed to explore the perspective of student nurses towards mental illness. The study was conducted by Khablein (2013) who pointed to positive views and understanding regarding mental illness among the students. Khablein

(2013) explored perceptions among students from Jordan, Syria and Iraq in quantitative/qualitative research that used both survey, focus group and interviews to explore the presence of stigma related to mental illness from the students' opinions. The results of the research showed that many students do not consider shame and stigma to be part of their perception to mental health problems. Additionally most students expressed that it should not be shameful for patients and families to seek medical help for mental health problems (Khablein 2013). Hence, it is not assumed in the current study that stigma is always part of nursing students' perception to mental illness and psychiatric nursing.

In summary, it seemed that nurses' perception to mental health nursing and working with psychiatric patients varies widely across world countries. It is also apparent that education, clinical training, experience, working environment and previous contact affect positive or negative perception of patients. It can be assumed that negative perception is not a permanent status and can be changed in response to educational needs and required facilities as expressed by nurses at different places. Hence, it was hoped in this current study in Cairo to establish a baseline of information regarding nurses' perception to psychiatric nursing and provide recommendations if possible to advance psychiatric nursing practice in Egypt.

2.6 Stigma and mental illness

Stigma associated with mental illness appeared as a significant issue within different literature (Goffman 1963, Romem et al 2007, Charleston and Hapell 2005, El Islam 2006, Eriksson and Hummel 2012, Link 2001, Coker 2005, Sidhom et al 2014). It is evident that understanding stigma associated with mental illness is vital in dealing with factors connected with it, such as different types of stereotype, prejudice and inefficient access to medical services (Link 2001, Secu et al 2015, Fitzpatrick 2015, Zubair 2015). Therefore, it is important to present a clear understanding of the concept of "stigma" so as to be able to map it, if participants of the current study express it. Although it was not clear if Egyptian nurses would articulate stigma as an

issue in their perception of MHN, it was important to understand the relationship between stigma and its effect on interpersonal interaction in order to recognize how it might affect nurses' perceptions towards MHN (Zubair 2015). Furthermore, existing stigma among health care professionals would cause a negative discriminatory attitude towards patients and threaten the therapeutic relationship (Zubair 2015). Therefore, the next part will discuss stigma and mental illness from different perspectives.

The word Stigma means labelling mark in the Greek old language (Goldman 2012). It is also defined as "Reactions to others that spoil normal identity and a discrediting attitude" and in many occasions it is associated with mental illness (Goffman 1963). Stigma also is considered one of the abnormal identities (Goffman 1963). The concepts of "normal and abnormal" were used to distinguish mental patients from healthy people in Arabic communities where a goal of the treatment is to regain the socially agreed normality as explained by El-Islam (2008). The discrimination that leads to stigma will lead the society to isolate, avoid or even punish the stigmatised person as argued by Foucault (1972).

The seminal work of Erving Goffman during the early sixties about stigma and social interactions is one of the enlightening references that explores the term stigma and clarifies its attributes. Goffman (1963) described stigma as difficulty accepting a person with specific attributes and putting this person in an inferior position to others. Goffman outlines three sources of stigma: stigma related to body deformities and other physical abnormalities, stigma related to mental disorders and stigma related to race, ethnicity and religion. The three sources of stigma are subject to interaction between attributes and stereotypes since the person is considered stigmatised if he shows differences from others who are described as the "normal" (Goffman 1963). Hence, it is suggested that perception of a person will determine interaction with this person according to his level of differentness and dangerousness. Applying Goffman's theory to Egyptian student nurses who live in a society that stigmatises mental illness (Sidhom et al 2014, Coker 2005) suggests that this might have an effect on nurses' perception of patients and this is what the

current study is about to discover. Although considering people to be different was not limited to psychiatric patients and might extend to a person who does not follow the rules drawn by the society, yet, mental illness was identified as one of the main sources of stigma (Foucault 1972, Goffman 1963). However, from Goffman's point of view the distinction between 'normal' and 'stigmatized' is not well defined, since there is no universally agreed definition of what would be normal and who will be subject to stigma (Kusow 2004).

Goffman (1963) differentiated between 'the stigmatised' who fail to meet society's expectations compared with others in the same age, sex, profession, and education, and the others who are considered as 'normal'. This dangerous classification puts the stigmatised person, such as the mental health patient under threat of prejudice, discrimination or disregard by the society (Goffman 1963). Hence, Goffman's opinion is one of the cornerstones for current study, since exploring nurses' perceptions about MHN will reveal how nurses perceive patients and whether stigma towards mental illness is an existing issue among nurses in Egypt. Goffman (1963) suggests that some groups, such as Gypsies and specific religious groups, may bear a stigma and but may not really care about it or society's shameful view of them. The same opinion was presented by Kusow (2004) who raised the question of who stigmatises whom; diverse cultural and ethnic groups who might be perceived as stigmatised in a specific society may themselves hold beliefs that stigmatise the society itself. As yet, there is no research evidence that mental patients would have this power of overcoming the stigma. This power was evident on only one occasion, when the researcher visited an old psychiatric hospital in Cairo and met patients who had lived in the hospital for twenty years and more and had recovered, but continued to live there. This group of patients had no option except living in the psychiatric hospital, because their families abandoned them and they lacked all support systems outside the hospital. They were able to constitute a strong group together to support each other and did not care about the society's opinion. However, this situation represents an individual experience of ex-patients not current patients and cannot be generalized.

Goffman (1963) also highlights stigma from the view of the stigmatised. He explained that the awareness of stigmatised person of their inadequacies and deficiencies could constitute a barrier and a source of anxiety. Furthermore, he highlighted the senses of uncertainty, fear and worries that may happen to the stigmatised person if he came in direct contact with others. Such negative feelings could be experienced by patients with mental illness if they felt stigmatised by others who are 'normal' such as nurses. Thus, understanding nurses' perceptions of MHN and exploring the presence of stigma among nurses may help to decrease the psychological burden on nurse/patient relationships. The following part will explore the effect of stigma from the perspective of the Arabic culture.

2.7 The effect of Arabic culture on mental illness: the selective sympathy

Professor MFK El-Islam is one of the significant writers who studied the effect of culture on mental illness in Arabic communities. His seminal work is considered a main reference for many researchers within the Arab world and worldwide. In his writings, Professor El-Islam asserts the role of Arabic culture in influencing the clinical presentation of mental health issues and how society perceives it. His writings uncovered the hidden influence of culture and stigma on mental illness (El-Islam et al 1986, El- Islam 1994, El Islam 2001, El Islam 2002, El-Islam 2006 El-Islam 2008). This was illustrated particularly in describing women's distress caused by reasons such as young girls' marriage, enforced withdrawal from education and the use of contraceptives; reasons that many claim are prohibited by Islamic teachings. Thus women have a conflict between societal change and cultural demands. El-Islam highlighted many factors that lead to psychological distress and depression. For example, he refers to the issue of selective sympathy or conditional sympathy where the patient may receive sympathy according to the reason of distress. He uses the example of a woman who lost her son and developed mental health problems; for this reason she may be worthy of sympathy and support. Yet, this sympathy will decrease if the reason of depression is related to an arranged marriage, domestic violence or limiting personal freedom and education opportunities (El Islam et al 1986, El-Islam 1994, El-Islam 2001, El-Islam 2006). Another example of the variable sympathy with mental illness

based on etiology of the illness is the evident lack of sympathy for, and stigmatisation of, alcohol abuse due to social and religious constraints of consuming alcohol in Egypt (Coker 2005). The question that was not asked in Coker's study is "are nurses and student nurses' perceptions of MHN affected by the ideologies of the society?" One can question whether prospective nurses' perceptions reflect judgmental issues regarding patients who suffer from mental health problems. Similarly from the literature review a further question can be suggested, "do the societal ideologies reflect on nurses' career choice". These questions will be explored in the current study.

2.8 Mental Illness in Egyptian Drama

Examples from Egyptian drama present different aspects of this society's empathy and compassion for patients suffering from mental illness. This is represented in Egyptian literature & novels that described the collective consciousness at that time. One novel (Al Haram- The forbidden by Youssef Idris (1959) was transformed to an Egyptian film. The characters in the novel and film would ask the mentally disabled person the same question every time "OHH Demian... is it Heaven or Hell..?" and waited for his answer so they can recognize the right decision in many situations. Accordingly, the mayor of the village would avoid the decision if Demian said "Hell" and go for the decision if it was "Heaven". For example, once Demian said "hell" when the village mayor asked him if he should tell about the woman who accidentally killed her newborn; the mayor listened to Demian and hid the whole issue.

A similar example was shown in the Egyptian film '*Mabrook & Bolbol*' by Gaber (1998), where the village loved and protected the mentally disabled and succeeded in keeping him away from the police who wanted to take him into a psychiatric asylum. The same idea of kindness and caring behaviour for a homeless woman with mental illness is shown in the film "Toot Toot" by El Shmaa (1993), where people used to give the woman food and care for her newborn although they knew she was subjected to sexual exploitation and got pregnant without being married. Egyptian community's empathy with mental illness was introduced many times in the drama and reflected part of society's

view; However, other sides of the truth regarding perceptions of mental illness and MHN need to be uncovered.

2.9 Summary of main points from the literature review

- Mental health services in Egypt are affected by the shortage of psychiatric nurses in the country and by the difficulty of accessing psychiatric services.
- There is extensive stigma associated with mental illness in Egypt and different Arab countries. This stigma extends to the whole family of the patient and among his/her health care providers.
- The stigma of mental illness sometimes could be one of the factors that deprive patients of treatment. Mental health problems are hidden sometimes to avoid bringing shame to the family.
- Nurses' opinions vary widely and are not always negative. Certain research studies show positive perception and acceptance of mental illness and mental health nursing.
- Psychiatric nursing is not one of the favored specialties among nurses, but the situation needs to be explored in Egypt.
- Some literature describes empathy with patients among Arabic community.
- There is lack of knowledge about whether student nurses' perceptions of mental health and illness reflect the perceptions of Egyptian society
- Nurses' perceptions of MHN in Egypt need to be explored.
- Education, clinical training, work environment and previous contact with patients are factors that could influence perception to mental illness and psychiatric nursing.

2.10 The research question and study aims

After reviewing the literature available and identifying areas where further research was required, the research question was developed as follows:

What is the perception of Egyptian undergraduate nursing students towards mental health nursing?

The research aims to:

- Investigate Egyptian student nurses' perception of working with mentally ill patients.
- Explore factors that influence student nurses' perceptions of MHN

CHAPTER 3

The Research Methodology

3.1 Introduction

This part of the thesis will discuss the research approach, theoretical framework, methodology, data collection and analysis with justification and critical analysis for each decision taken during the steps of the research process. The influence of the researcher will also be highlighted.

The study took place at the school of nursing at Cairo University. Nurses' perceptions of psychiatric nursing have been examined by multiple researchers in Canada, Australia, USA, South Africa and the UK (Harrison et al 2014, Van Rensburg et al 2012, Van Rhyne and Gontsana 2004, Wantzet et al 2012, Charleston and Hapell 2005, Kraglund 2011, Browne et al 2013). Yet few research studies have been conducted in the Arab world including Egypt. This gap in knowledge is accompanied by calls from the WHO (2015) to increase attention on training in psychiatry and mental health for both physicians and health care providers. This encouraged the researcher to start an in-depth investigation regarding MHN and to explore factors that influence nurses' perception towards psychiatric nursing. This study aimed to provide a well-defined picture regarding the research question and to inform future curriculum development based on students' opinions. The research is a critical inquiry based on a qualitative research approach using focus group interview to understand student nurses' views and opinions through an exploratory descriptive study.

3.2 Theoretical underpinning and nature of knowledge of the study (justification of methodology)

Qualitative research
Exploratory descriptive study
Constructivism epistemology
Focus group method for data collection
Content analysis for data

Summary of research steps

This study is an exploratory descriptive study since explanation and interpretation of participants' perspectives is explored regarding MHN. Exploratory descriptive studies are used when participants are invited to share their senses, meanings and experiences for their social reality (Flick 2014, Creswell 2014). This approach is congruent with current study that aims to understand meanings and perspectives of MHN from students' views and understand how other factors such as culture, learning experience, placement might play a role for each individual perception.

The research question is : What is the perception of Egyptian undergraduate nursing students towards mental health nursing?

Little is known about this topic the current study is an exploratory descriptive study, therefore choosing qualitative research paradigm is important due to the lack of basic information regarding MHN in Egypt. Marshall and Rossman 1999 and Polit and Beck 2012 differentiated between two main purposes for a qualitative research: that is exploratory descriptive studies where a phenomenon not explored in literature is being described such as is intended in the current study. The other purpose for a qualitative research is explanatory research that explains the connection between an event or a phenomena and how participants interact with it. They clarified that qualitative studies could use the descriptive approach or the exploratory approach or both of them. Descriptive approach is used to describe an under-researched topic while exploratory approach is used to highlight factors that affect participants' perception to the topic. Therefore, the current study approach is an exploratory descriptive study as it draws on nurse's perception towards MHN and articulates factors that affect this perception. Deciding the nature of knowledge and the research approach as exploratory descriptive will influence the nature of inquiry during development of the focus group question guide as clarified in Appendix 1 to address aims of the research.

Reviewing the literature led the researcher to focus on how students develop and understand the reality of mental health and nursing based around the seminal theory of the social construction of reality (Berger and Luckman 1971), since the research question is focusing on perceptions of part of the Egyptian society who are nurses. Marshall and Rossman 1999 and Willing 2013 emphasized the importance of developing a conceptual framework,

deciding on the nature of inquiry and the philosophy and type of knowledge and knowledge claim as an initial stage of the research. Therefore, it was important to explore and determine different types of knowledge and philosophies behind the research at an early stage of the study.

From another point of view regarding types of knowledge generation, Creswell (2014) identified four alternative knowledge positions, post-positivism, constructivism, advocacy and pragmatism. Each knowledge position is concerned with a specific type of knowledge generation and reality interpretation. However, constructivism is congruent with the nature of the current study as it is based the interaction between an individual and society (Berger and Luckman 1971) and thus the knowledge expected to be generated from the study. A similar view from Crotty 1998 clarified that qualitative research depends on understanding meanings and perceptions of participant's engagement with the world. Both the social and historical background of participants in this research influences engagement and interaction with the topic of mental health nursing and student nurse perceptions. Constructivism is concerned with understanding participants' views and generating theory of knowledge based on cultural interaction between participants and their society (Creswell 2014) Consequently constructing knowledge that answers the research inquiry will apply to this current study where perceptions and opinions are the focus of the inquiry for constructing knowledge.

In describing constructivist epistemology, Creswell mentioned "The goal of research, then, is to rely as much as possible on the participants' views of the situation being studied. The questions become broad and general so that the participants can construct the meaning of a situation, a meaning typically forged in discussions or interactions with other persons. The more open-ended the questioning, the better, as the researcher listens carefully to what people say or do in their life setting" (Creswell 2014 p.8).

Qualitative research method is chosen for the current study as it aims to draw on student nurses' perceptions regarding MHN in order to obtain meanings and experiences (Castellan 2010, Holloway and Wheeler 2010, Silverman

2009). Furthermore, using qualitative research in nursing education is a powerful tool for providing descriptions of students' learning experiences, and feedback on courses and clinical placements (Hold et al 2015, Foster et al 2014, Carlson et al 2014, Carver et al 2013, McKendry et al 2013, Sharif and Masoumi 2005, Willing 2013). Therefore, it was expected in this research to generate in-depth data using qualitative methodology to shed light on perceptions of MHN.

The research aim of the current study is to explore and describe student nurses' perceptions of MHN, to hear their voice and explore their experiences and opinions about this field of nursing. Also the research aims to explore factors that influence student nurses' perceptions of MHN. Choosing a qualitative research paradigm is important due to the lack of basic information regarding MHN in Egypt. Therefore, exploring this humanistic social topic requires a start with a qualitative exploratory study that aims to present basic data on the topic and in-depth perceptions of it (Hancock et al 2009, Willing 2013).

Another reason for the selection of the qualitative research method is the previous experience of the researcher with nursing school students whilst conducting a quantitative study that included gathering data from 400 students through questionnaire survey. The researcher was responsible for the data collection stage of the study, with a team of 3 other researchers. The research aimed to explore student nurses' opinions regarding the use of electro convulsive therapy (ECT) as a method of treatment in mental health. The data collection using questionnaire survey with the school nurses faced some difficulties. For example, difficulties started when many students were worried that their opinions would be considered wrong. The researcher affirmed that surveying their opinions was not a matter of right or wrong and they were free to express what they thought. Some students started to talk to each other during the survey and to discuss results with each other. Responses were changed based on their colleagues' advice. Also, many questions were left blank because students expressed that they were not sure about the answer. Freitas et al (1998) discuss this point and highlight that focus group can be a preliminary stage that precedes a survey to enable the

researcher to identify main themes for setting survey questions and to develop realistic goals for the research. Therefore, the researcher believes that generating qualitative data through interviewing groups of students is more suitable for exploring students' perceptions of a specific topic about which little is known. As a researcher new to focus group interviewing, opportunity was taken during study weeks on the doctoral programme to attend a workshop on focus groups, where the participants were able to practice managing and observing a group and also how to ask questions of the group.

This description matches what is intended to take place during the current study, where the aim of focus groups is to ask participants open-ended questions regarding what would they think of MHN and to observe the flow of participants' discussion. It is important to decide the type of knowledge and theoretical position of the researcher to detect any personal bias and guarantee trustworthiness of data. Hence, during the current study, the researcher did not make any assumptions about perceptions of MHN or influence the opinions of participants; some clarifying questions only were asked. The constructivist epistemology also influenced the ground rules of the focus group discussions where an important rule related to the neutrality of the facilitator, who should not criticise or praise the different opinions expressed by participants. Detailed discussion of running a focus group and the data collection process is given in the next part.

3.3 Methodology

This section explains the processes undertaken to do the research. Firstly sampling is addressed followed by data collection methods.

3.3.1 Sample recruitment:

It was important to recruit the sample so that they could contribute to the discussion in the focus group from a base of knowledge. Therefore, the researcher chose to recruit student nurses who are about to graduate in the final (4th) year of study. It was decided based on experience that fourth year students are able to inform the study with answers based on their

accumulated knowledge for the four years of study either at the faculty or school of nursing. Also students who are about to be graduated have the experience of studying all branches of nursing and been to clinical placements where they met and worked with many patients including mental health placement. Hence, choosing students at final year of study will ensure the sample can discuss with knowledge and data based on their experiences and will be able to make some decisions regarding career choice at this stage. This information wouldn't be available if I invited first or second year students who did not have knowledge about MHN yet.

Originally the plan had been to recruit students by e-mailing them as, at the time the researcher was working in British University of Egypt Nursing faculty. Farrokhi 2012 and Etikan et al 2015 clarified that convenient sample is a nonprobability and nonrandom sampling strategy and argued that students at own researcher's institution can be seen as purposeful sample – this was the original plan with students at BUE. However, due to the possibility of researcher influence as the student's lecturer it was decided to change the place of the study. Recruitment took place after approval was obtained from deans of nursing faculty at both the MTI and school of nursing. The total student numbers constituted 180 students and the researcher announced the research project to all of them. This was achieved by going to students' classes for 15 minutes to explain the idea of the study and different aspects of the research. This required extensive coordination with programme academic leader to find time within student's schedule. At this stage copies of information sheet (Appendix 2) were available for students to take to supplement the oral presentation by the researcher. The researcher chooses not to use emails for communicating the research idea and recruiting sample because the school of nursing does not support students with computer system or organization internal emails. Also not all students have access to internet, nor personal emails to facilitate communication with them. Therefore, it was easier to complete the sample recruitment stage by the researcher through arranging meeting to access school classes directly.

Convenience sampling is used for this study. At the stage of deciding the sample strategy for the study; as the aim is to recruit participants who have

specific qualities, characteristics and homogeneity, experiences and knowledge to inform the study (Patton 2002, Suri 2011, Marshall 1996, Palys 2008, Palinkas et al 2013, Farrokhi 2012). Purposeful sampling is appropriate in qualitative research and focus group methodology (Doody et al 2013, Suri 2011, Tuckett 2004, Nagle & Williams 2011, Willing 2013). However, purposeful sampling would need a broader recruitment strategy to enable generalization of results and would require representation of wide-ranging groups of participants (Patton 2002). Using purposeful sampling strategy for this research would need expanding participants' recruitment to include other schools of nursing within Cairo and other governorates to obtain reliable and consistent results that represent opinions of most nursing students around Egypt and their views to MHN. However, this was difficult to achieve at this level with the professional doctorate research and unstable political situation and unrest at the time of research application. Hence a convenient sample was chosen to be used in current study to include accessible nursing students at both MTI and school of nursing without obligation to generalize the results and widen representation of broader participants from different places. Also convenient sample is suitable for targeting group of participants who are accessible, willing to participate in the study and are able to answer the research question (Etikan et al 2015, Patton 2002). These characteristics apply to the nursing school students whom are able to answer the research aim as the researcher expected, yet, they do not represent the opinion of all nursing students around Egypt.

The researcher was aware to some limitations of convenient sampling and to take it into consideration during sample recruitment. One of these limitations is that convenient sample could be biased by the researcher's "self selection" of participants as argued by Farrokhi 2012. The researcher did not want to influence the results of the study through planning to choose specific opinions of students' perceptions. Therefore, the researcher did not establish students views in relation to who would like to work at MHN or participants who expressed refusal to MHN placements to avoid bias that could happen if participants have a specific predetermined opinion about MHN or agenda to work at MHN.

3.4 Data Collection

Focus group was used as the method for data collection. This section will explore various methods of data collection and provide justification for using focus groups and reports on each step taken during the research process.

Total number of focus groups	8 focus groups
Number of participants	32 participants
Gender of participants	All females *All students at the school are female
Age of participants	From 17 years to 19 years old
Year of study	4 th and 5 th year students are invited to participate
Timeframe for each focus group	Ranged from 35 minutes to 60 minutes
Place of pilot study	MTI faculty of Nursing
Place of focus groups of the study	The school of nursing, Cairo University

Exploring methods for data collection

Qualitative research data collection can be done through different methods such as interview (structured, semi structured and unstructured), focus group, observation, and analysis of texts and documents (Braun and Clarke 2013, Yin 2011, Ritchie and Lewis 2003, Silverman 2009, Creswell 2009, Gill et al 2008).

Interview is considered the most common method for qualitative data collection, used mostly to explore experiences of participants (Braun and Clarke 2013, Sewell 2016). The three types of interview aim to provide in-depth information and understanding of a specific topic through exploring participants' opinions and perceptions of the topic (Tuner 2010, Turner 2010, Creswell 2009, Gill et al 2008, Elliott and Timulake 2005, Sewell 2016). Interview can be conducted with an individual or in groups, with direct contact between researcher and participant face-to-face, or at distance by telephone interview (Opdenakker 2006). Successful interview depends mainly on good preparation and the researcher's experience in planning and facilitating the

interview (Braun and Clarke 2013). Using face-to-face interview as a method for data collection gives the researcher a chance to capture verbal and nonverbal communication, and the emotions and body language of participants that could reflect different interactions and feelings (Silverman 2013, Turner 2010, Opdenakker 2006). One to one interview could be seen as a costly and time-consuming method for data collection (Sewell 2016). Also, the autonomy of participants can sometimes be questioned in one to one interview if an interviewer influences or manipulates the flow of discussion. A participant might also experience a feeling of unease or discomfort when trying to answer certain questions (Opdenakker 2006). Silverman (2013) also notes that an important issue for qualitative researchers to consider during interviews is the difficulty of assuming that interview will give the researcher access to participants' thinking and will provide clear or abstract answers to the research question. Participants may not hold a single meaning for each experience and might express different perspectives based on diverse settings. In the current study, the researcher assumed that nursing students would feel safe within focus group discussions to express their opinion in a group and engage in rich discussion to enrich the results of the study. Using an interview guide (Appendix 1) was one of the aspects designed to facilitate the discussion, to increase the focus on the research aim and to diminish the personal effect of the researcher as much as possible.

Observation is another method for qualitative data collection where the researcher observes and records field notes on behaviours, interactions and activities of individuals at the research site (Creswell 2009, Gill et al 2008). Observation as method for qualitative data collection can be useful in allowing the researcher to attend to and observe details of behaviour and to explore unusual and unexpected aspects of participants' interaction. Observation can be either participatory or non-participatory according to the aim of the research and the level of involvement and engagement required from the researcher (Lapan et al 2012). Observation gives the researcher the chance to compare the pattern of individuals' interactions in specific situations and understand the way participants do things, connect and relate in different

situations (Lapan et al 2012). However, observation depends mainly on personal qualities and skills of the researcher such as ability to observe, interpret and connect information (Creswell 2009). Another limitation of observation is that participants may perceive the researcher's presence as intrusive or causing unnecessary interruption or interference (Creswell 2009). Observation was not applicable as a method for data collection in the current study as opportunities to observe students are not readily available; students rarely go to mental health facilities for training or provide nursing care to a patient who suffers from mental illness. Observation was also excluded as a method for data collection because the current study sought to understand perceptions and opinions and not to observe specific attitudes and behaviours in a direct care context.

3.4.1 Focus Group Method and rationale for its choice

This section will provide explanation of the rationale, advantages, complexities and stages in using focus groups.

Focus group is one of the highly used methods for qualitative research data collection (Henninkin et al 2011, Dereshiwsky 1999, Doody et al 2013, Holloway and Wheeler 2013, Morgan 2013, Then et al 2014). Focus group discussions allow elaboration of information through rich conversation between participants (Smithson 2000, Elliott and Timulake 2005). Therefore, focus groups are defined as *“group discussions exploring set of issues. The focus group is focused in that it involves some kind of collective activity and distinguished from the broader category of group interview by the explicit use of group interaction to generate data”* (Barbour and Kitzinger 1999, p.4). Referring to this definition, it is apparent that focus group is more than inviting a group of people to meet and talk about an issue. Preparation for effective group interaction is an integral part of a successful focus group. Therefore, the process of preparation and steps for focus group will be discussed in this part of the thesis to reflect progressions that took place during the study in Cairo.

Focus group methodology has a significant place in nursing education. Kevern and Webb (2001) in their nurse education study emphasised the value of focus groups as a method of qualitative data collection. They found the method to be useful for describing nursing students' learning experiences, opinions and feelings. Using focus group methodology with nursing students enabled them to obtain more comprehensive data around students' experiences than would have been obtained from quantitative questionnaire data.

In an exploratory descriptive approach, focus group is a preferred method for qualitative data collection when exploring a new topic (Doody et al 2013, Morgan 2013). The value of focus group as a data collection method for qualitative research comes from its ability to generate knowledge and explore perceptions of participants and describe their experiences regarding the researched topic (Then et al 2014, Krueger and Casey 2000, Willing 2013, Smithson 2000). Usually data generated through group interactions reveal perceptions and enriched opinions and may uncover facts about the researched topic (Carey 1994). Hence, it was expected that a focus group would provide in-depth knowledge regarding student nurses' perceptions of MHN in Egypt. Focus group research could be followed by questionnaire surveys and in-depth interviews as a second stage of research, after presenting initial understandings of the research topic from analysing the focus group data (Doody et al 2012, Then et al 2014). However, in this current study, focus group is used as a first stage for data collection. Further study using different methodology might be suggested after completing the focus group data analysis.

While focus group is one of the well-appreciated qualitative research methods, it is important to determine if it is the methodology that suits the purpose of the study and provides an answer to the research question (Larson et al 2004). For example, Larson et al (2004) argued that focus group is not suitable for building consensus or evaluating an educational programme and indicated that surveys are more suitable. Also Flick (2014) emphasised that discussing sensitive issues, accessing narratives and understanding

individual experiences are difficult to achieve through focus group since group discussions interrupt the flow of conversation. Another limitation for using focus group is that shy participants might be afraid to talk or unsure about joining in or 'interfering' in the discussion and may lack confidence about their answers (Flick 2014).

The current study did not expect or search for agreement of opinions about MHN and all contradicting opinions expressed by participants were valued and objectively interpreted. Therefore, the researcher intended to avoid any verbal or non-verbal sign of rejection of any opinion expressed during the focus group and worked to moderate the discussions in a facilitated way (Then et al 2014, Krueger and Casey 2000). Moreover, keeping positive relationships between researcher and participants during focus group interview requires mutual respect for participants' opinions, showing understanding and active listening (Holloway and Wheeler 2013, Dereshiwsky 1999). Consequently, acceptance, active listening and facilitation were significant skills to consider prior to starting the focus groups.

Recognition of focus group characteristics was important prior to starting the study to enable appropriate planning for the focus group and in order to get the most from each interview. Krueger and Casey (2000) identify characteristics of a focus group:

Characteristics of focus groups:

- Focus groups involve people
- The people possess certain characteristics
- Focus groups provide qualitative data
- Focus groups have a focused discussion

Krueger and Casey 2000: P. 10

In relation to the current study, it is apparent that focus group is suitable for obtaining qualitative data with some consideration given to the homogeneity of participants, logistics, and the focus of the discussion. In addition, there are

some qualities and characteristics of the researcher that need to be considered, such as facilitation skills and communication skills when leading the group (Kielmann et al 2011, Puchta and Potter 2004, Krueger and Casey 2000). Therefore, it is important to decide the type of knowledge and theoretical position of the researcher to detect any personal bias and guarantee trustworthiness of data. Hence, during the current study the researcher did not adopt any assumption about perception to MHN during the questioning in focus groups, neither interfered with the opinions of participants except for some clarifying questions. She undertook a workshop, during her previous doctoral modules, relating to conducting focus groups and within this practiced the techniques of questioning and remaining detached and neutral.

3.4.1.1 Disadvantages and limitations of the method

Some disadvantages of using focus group method were evident during the current study, disadvantages such as reluctance of some participants to express opinions and feelings for fear of being judged or mistaken by others (Then et al 2014, Flick 2014, Henninkin et al 2011). Another disadvantage of focus group clarified by Henninkin et al (2011) is that some participants might dominate the discussion and want to direct the opinion of others towards a specific point of view or even control the flow of discussion towards a specific opinion. The researcher was aware of this challenge and tried to facilitate the discussions giving members equal opportunities to express their points of view. Also it was clarified at the beginning of each interview that everyone was free to express her own opinion without any fear of being judged. Also facilitation skills were required for providing support and encouraging participants who were silent or reluctant to express their opinion (Bell 2010, Silverman 2009, Flick 2014). This happened occasionally during some focus groups and the researcher had to observe for active and passive participants. Henninkin et al (2011) point to the importance of motivational probing as a core responsibility for the researcher to successfully moderate the discussion. Therefore, participants who kept silent most of the time were encouraged to express their view through asking them if they agreed with a point or if they faced similar situations they wished to share. Also the researcher had to repeat some questions to participants who hesitated to talk, with reassurance

that this was not a matter of right or wrong and that all opinions are accepted. This worked most of the time without putting pressure on participants to share any knowledge.

Setting ground rules was another strategy to maintain the sense of safety among participants. This required basic rules to be followed by participants and facilitator to maintain the feeling of safety, comfort and respect in a non-stressful atmosphere. These rules are explained by Nagle and Williams (2011) who point out the importance of respecting and valuing each other's opinions, minimising interruptions, and turning off cell phones. Those ground rules (Appendix 2) were clarified to participants at the beginning of each focus group. Any participant blaming others for their opinions had to be stopped. However, some communication conflicts did happen during the discussions. For example, some students tried to correct their friends during the interview and at times started to blame each other. The researcher had to provide some clarifications about ground rules (Appendix 2) for respecting each other's opinions and to allow each member to express her own view of the topic and to respect each other's opinions. This is a cultural challenge for the participants.

Controlling the researcher's own opinions and being neutral about what is expressed by some participants was not an easy task. Sometimes denial and refusal appeared in my tone of voice and facial expression during the first two focus groups. It was challenging at some points to agree or even keep neutral with what had been expressed by some students in relation to perceptions about mental patients. Some opinions were offensive and stigmatising to patients and showed some kind of discrimination against patients. However, it was useful to listen to the audiotapes and transcribe them immediately after each interview to capture any verbal comments or change in the researcher's tone of voice that could be perceived as condemnation or disapproval. While this happened during some of the initial interviews, avoiding it during the rest of the interviews was reinforced.

Moderating focus groups and leading the discussions for several groups is a skill that is developed with practice, reflection and feedback. Usually, a focus group is seen as an informal discussion that requires homogeneity among its participants to encourage the flow of discussion. Selection of focus group members requires the group to be similar in some characteristics such as age, sex, educational background and hierarchical position (Carey 1994, Silverman 2011). Homogeneity between group members is essential to help in encouraging group interaction and enable members to feel safe to express their views and relate to each other (Ritchie et al 2014, Willing 2013, Vaughn et al 1996). For this reason, members of each group in the current study chose each other and decided which group they wanted to be in. Also when the focus group was conducted among fourth and fifth year students of the nursing institute, the researcher avoided mixing both years and preferred to keep the group from the same year of study. Ritchie et al (2014) suggest that heterogeneity could be useful for generating rich discussions. Yet, a mixed background group could inhibit the spontaneity of discussion and create an atmosphere of discomfort (Dereshiwsky 1999). Also heterogeneity could be seen as a threat for some participants who might feel uncomfortable to express their opinion if it did not agree with the flow of the discussion. However, the small participating groups that have homogeneity among its members might reduce pauses or interruption of discussion (Ritchie et al 2014). Therefore, students from the same class and the same year were invited to participate together.

Gender issues and the limitation of “performing” are obstacles that might influence the end results of an interview (Holloway and Wheeler 2013). However, this problem did not exist during the study since all students at the school and institute of nursing were female.

The researcher was aware of integral role of facilitation during discussions and of the need to avoid leading the discussion (Carey 1994, Silverman 2009, Seal 1999). Therefore, the researcher tried to keep her interruptions to group discussion at minimal level when group members interacted to formulate an

opinion, for example when discussing issues such as their opinion of their knowledge background and their experience of MH clinical education.

The place of conducting the focus group was an important consideration. The place should preferably be familiar, calm and accessible to participants (Cronin 2011, Then et al 2014). Therefore, all the interviews took place at the school of nursing in classes familiar to students. One of the obstacles was noise, since the school of nursing is located at the heart of the faculty of medicine in Cairo University. Some classes were shared between nursing and medical students on the same days. Therefore, it was arranged with the floor supervisor of the classes to find an empty class for one hour each interview day. Also, teachers were informed about each interview day, timing and class number to avoid any overlapping of schedules or interruptions to student-teacher meetings.

3.4.1.2 The nature of questioning in focus group interview

While survey and questionnaire usually depend on closed questions, focus groups provide in-depth information about the research topic using open-ended questions (Nagle and Williams 2011, Krueger and Casey 2000, Morgan 2013). Open-ended questions are the main source of data for focus groups (Krueger and Casey 2000, Silverman 2009, Kielmann et al 2011, Willing 2013). During the interviews particularly the first two, most of the questions seemed to be closed: for example

“I noticed that you all rated it to be as the worst specialty... do you mean by this that you don't like to work as a MHN? (Amira – First focus group)

“So you think nurses lack experience and knowledge regarding MHN (Amira-second focus group)

“You are all at the 5th year, and about to graduate... will you consider mental health as a specialty? (Amira- second focus group)

Listening to tapes and doing the transcription immediately after the interview revealed that participants could be encouraged to provide more details if the type of questions changed. This required review of literature regarding open ended questions and how to structure them (Gillham 2000, Puchta and Potter 2004, Silverman 2009). Therefore an interview guide was developed after the

second focus group to inform the points of discussion and the type of questions to be used (Longhofer et al 2013). Changing the question type and observing the use of open-ended questions required training and changed with experience. Question type in the fifth and sixth interview reflects this change: for example

“Can you tell me about your experience during the mental health training”
(Amira- focus group 6)

“let me know further about the society’s perception to mental health nurse”
(Amira- focus group 6)

Focus group interview differs from individual focused interview in that the first depends mainly on the collective thinking and interaction between group members, while the individual focused interview focuses on exploring a topic that is familiar to the participants without the need to follow group interactions (Redmond and Curtis 2009). Hence, facilitating focus group requires close observation from the researcher regarding the implications of interaction and nonverbal communication that takes place during the discussions (Cornin 2011, Hancock et al 2009). Therefore, I kept to a low involvement pattern, except for clarifying questions or encouragement sentences to motivate participants to expand details on a specific point (Freitas et al 1998). Low involvement gives the researcher the chance to observe nonverbal communication for group participants and reveal issues such as the dominance of certain participants’ opinions that occurred occasionally during discussions’ and some avoidance behaviour from other participants (Freitas et al 1998). A critical interpretation regarding group interactions and discussions will be explained in detail in the data analysis section.

3.4.2 Data collection settings

The research took place at two different premises, MTI for the pilot study and the school of nursing Cairo University. Both places welcomed the research and guaranteed access to students to conduct the focus groups.

Required characteristics of qualitative research include flexibility, ongoing analysis and involvement of the researcher in every step of the study (Polit and Beck 2012, Hancock et al 2009, Creswell 2014, Daniel and Turner 2010). These characteristics were manifested at different occasions during the study. Flexibility was required to change the place of research at the beginning of the study. Access to educational organizations to meet the students and start the study was challenging at the beginning. The study site had to be changed from the British University in Egypt (BUE) to other places such as the faculty of nursing at the MTI and the school of nursing. Negotiation for access and explanation about the research aims and time frame required meetings with the Dean of both places (MTI & school of nursing) to gain initial approval from both places. Studying at Queen Margaret University, Scotland was one of the factors that facilitated access to educational organisations in Cairo since it is well-recognised name for cooperation with the BUE.

Only one pilot focus group took place at the MTI due to the very low number of students who were less than 20 in the fourth year and only three of them agreed to participate in the study. Therefore, a second site was required to continue the study. Hence, the school of nursing was the second choice since it includes five years of study and around 800 student nurses. During conduct of the study at the school of nursing, at Cairo University, the researcher had to negotiate the time and place for each focus group with the year coordinator at the school of nursing prior to the interview. This was due to the busy schedule of the students and the limited availability of classrooms. Therefore, the time plan for conducting the interviews was developed during the study and not predetermined. Another issue that required flexibility was the sequence of questions during the focus group. Although there was a predetermined focus group question guide (Appendix 1), the sequence of the questions varied each time based on the interaction between the group and the flow of conversation. Also the focus group guide was edited several times based on data obtained from each interview. This flexibility helped to obtain detailed and comprehensive views from participants without adherence to a specific sequence of questions.

Nagle & Williams (2011) identified two stages of preparation that have to be considered after the study purpose is determined and prior to starting focus group interviews. Those two stages were defined as conceptualisation and logistics. During the conceptualisation stage, planning details of the research process took place, details such as sample identification, sample size, determining the group participants and obtaining approvals, and developing the discussion guide. During the study, some complexities interfered with the predetermined conceptualisation, such as in the sample size. The size of the sample, was planned to be from 6 -10 as recommended by Krueger and Casey (2000). Yet, this was one of the challenges, as the focus groups ranged between 3 to 5 participants only. This was due to the availability of students and the numbers agreeing to participate. Some literature suggests that the number in a focus group should range from 6 to 12 (Blackshaw and Crawford 2009, Silverman 2009). Ritchie et al (2014) explain that a small number in a focus group can be accepted when seeking in-depth understanding of group members' point of view about the research topic. The other factor that led to a small number in the focus groups related to the researcher herself who preferred to divide groups consisting of 8 or 9 into two groups. The researcher felt more in control of the discussions with groups up to 5 and recognized how challenging it is to keep the power balance among group opinions during the discussions. It is the facilitator's responsibility to keep rules for the group discussion and maintain a safe atmosphere for participants to voice their opinions (Morgan 2013). These facilitation skills developed and varied with the different focus groups.

In the current study, the researcher conducted only one or two focus groups per day with students who agreed to participate in the study. This decision was due to the amount of effort and time required to transcribe each interview tape, and the need to start this transcription immediately after the focus group and starts at the same day of focus group and extend to a week for each two focus group transcription. Therefore, it was possible to run only one or two focus group at each weekly visit to the school of nursing. In summary therefore: In the pilot study, the participants were three students from the MTI faculty of nursing. In the main study, the participants were 4th and 5th year undergraduate nursing students who had completed the programme of study

and were waiting for graduation. All students were female. Eight focus groups were conducted with a total of 32 participants at the school of nursing premises at Cairo University.

3.5 Ethical considerations

Qualitative research has an emergent nature that requires ongoing decision making for each step of study; consequently, ethical issues need to be considered throughout the study (Creswell 2014, Clissett 2008, Ramcharan and Citchliffe 2001). In addition, it is important to consider ethical issues regarding the professional boundaries between researcher and participants where there is close engagement with participants in qualitative studies (Polit and Beck 2012). This part will describe decision-making that took place during the study and addresses ethical research guidelines within the study process.

Prior to starting the study, an ethical approval form was filled in and accepted by Queen Margaret University ethics research committee. Ethical approval also had to be obtained from each organization that the researcher accessed (Creswell 2014). This required developing an ethical approval request form that included aim of the study and a brief explanation about the project. Also included were the rationale for the study and its academic relevance, commitment to respecting the privacy of the organization and maintaining confidentiality of information obtained. The form was presented to both the MTI & school of nursing administration to negotiate access to both organizations to start recruiting participants of the MTI. Approval was obtained from both organizations and access to students was guaranteed for the study (Appendix 4 and Appendix 5). Meetings at both organizations included questions about the nature of the study, the researcher's work and qualifications, and the expected time frame for the focus groups.

Measures to ensure ethical considerations with participants required planning and continuous observation during each step of the research process. The aim was to inform participants, to protect them from harm and guarantee that ethical rules were observed (Creswell 2014, Willing 2013, Silverman 2009).

Therefore information sheets (Appendix 3) were distributed to participants and informed consents (Appendix 6) were obtained. In addition, developing ground rules for the interview, protecting anonymity and confidentiality and safeguarding of data were important ethical considerations. The following part will discuss these issues and how they were processed during the study.

3.5.1 Informed consent

Keeping participants informed of study objectives and scope is a significant part of trustworthiness and credibility of research (Creswell 2014, Holloway and Wheeler 2013, Flick 2014). Therefore, an information sheet (Appendix 3) was developed for dissemination to potential participants. It included brief information about the study details, time frame, benefits and relevance and contact details for the researcher. In addition to the information sheet, the researcher managed to arrange the opportunity to talk with potential participants to present the aim of the study and allow students to ask any questions they might have about the study. This took place once at the MTI with fourth year students and four times at the school of nursing where the number of students exceeds 100 in each year, sometimes divided into different classes.

Ensuring that potential participants had enough knowledge about the study was vital to enable students to decide whether they wished to participate in the study and sign the consent form. Informed consent was obtained from participants who expressed their willingness to participate in the study without any obligation or threat. All students were assured that no penalties or advantage would take place if students did or did not decide to participate in the study. This was done to guarantee that participants were not under pressure or obliged to participate (Halai 2006, Davies 2010, Creswell 2014, Holloway and Wheeler 2013, Flick 2014).

Informed consent seemed to be a source of anxiety to many students who expressed their lack of understanding regarding what they were signing and they questioned why they needed to sign the consent form, when they were committed to participating in the study. The researcher was aware that this

was the first experience for students of participating in a research project and provided further explanations for the importance of consent. The researcher decided not to push participants to sign the consent if they were worried and left it at the participants' choice (Creswell 2014). Self-determination and freedom to participate and withdraw from the study were asserted prior to starting the study (Davies et al 2010, Holloway and Wheeler 2013, Flick 2014). These principles were addressed during the first meeting with the students when introducing the research and when obtaining written consent. Students' dignity was respected and students were protected from coercion by confirming that participation in the study was not obligatory and there would be no penalty if they decided not to participate or withdraw at any point (Davies 2010, Polit and Beck 2012, Willing 2013, Flick 2014). It was also clarified that participating in the research was not related to any kind of advantage, such as to grades and it would not influence students' evaluation. Also respect was shown towards participants' opinions and they were thanked for participating in the study.

3.5.2 Beneficence and non-maleficence

Beneficence, the obligation to provide good, and non-maleficence, the obligation to avoid harm are two main research ethical principles to be considered during the planning and conduct of research studies (Howe & Moses 1999, Willing 2013, Polit and Beck 2012). The unique nature of qualitative research, which may include probing into some personal experiences of participants, requires critical thinking for each step to ensure beneficence and non-maleficence (Polit and Beck 2012). The researcher was aware that exploring students' experiences and opinions might cause anxieties and feelings of discomfort at some points. One of these was the responsibility for the researcher during facilitating the focus groups to protect participants from any potential criticism by other participants. Therefore, developing and agreeing on ground rules for the discussion was important at the beginning of each session. Also to avoid psychological discomfort for students the researcher needs to avoid putting pressure on participants to contribute to the discussion and should allow each participant freedom to express opinions. It is evident that in qualitative studies when seeking in-

depth information, mutual interpersonal trust between researcher and participants is needed to support a sense of safety among participants (Canadian Institute of Research Ethics 2015). To maintain the sense of security, the researcher took time to introduce herself to participants, to outline the research objectives, to provide her contact details and to answer any queries that participants had. It was emphasised that everyone was allowed to express and share their experiences without any obligation. This gave participants a sense of security that was evident from the flow of conversation and the amount of knowledge and experiences shared during each interview.

In terms of beneficence, it is suggested that research should have a potential benefit and value to participants or to the community (Creswell 2014). Therefore, it was explained prior to the study that results might potentially help to improve the quality of MHN services and care provided, and enhance mental health learning experience in the nursing field.

3.5.3 Confidentiality and anonymity

A qualitative researcher should be sensitive to issues that might cause psychological distress to participants such as confidentiality, anonymity and privacy (Creswell 2014, Willing 2013, Ramcharan and Cutcliffe 2001). Before obtaining consent, the researcher explained that the interview would be recorded, and that participants' names would not be used. The issue of tape-recording was problematic at times for some participants who started to ask about the reason for recording and where the data would be used. It was clarified that privacy and confidentiality of collected data would be maintained and that data would not be used in any form of evaluation and assessment. It was explained that codes would replace their names during the data reporting stage to sustain the sense of security and encourage them to express their opinions and share experiences without fear of being judged or evaluated. For example, in different focus groups, students had expressed some issues related to the quality of clinical placement and supervision and the need to enhance MHN education. Therefore, confidentiality was also maintained through other measures, such as not sharing participants' opinions with

school teachers to protect students from potential criticism or blame from them. Protecting confidentiality also related to storage of data obtained from the study. Therefore, safeguarding of stored data was achieved through archiving all records and transcripts in a classified part of researcher's computer. Password was set to access transcription documents and records to protect the data from unauthorized access, loss or modification (Canadian Institute of Research Ethics 2015).

Howe & Moses (1999) also note that in educational research, in relation to the integrity and quality of data, findings should be objectively presented.

3.6 Developing the interview question guide:

Developing the interview guide required extensive review of literature to identify the main themes for the expected discussion with the students. Stigma associated with MHN was one of the main themes in much of the literature and it appeared to be an important influence on nurses' perceptions of mental health patients and the career of MHN (Link 2001, Coker 2005, Sidhom et al 2014, Goffman 1963, Romem et al 2004, Charleston and Hapell 2005, El Islam 2006, Eriksson and Hummel 2012). The Centers for Disease Prevention and Control (CDC) called for more public awareness regarding mental health stigma in the USA. They asserted that stigma associated with mental illness should be condemned since it is a cause of more unneeded suffering for patients. Also, the CDC clarified that stigma of mental illness causes patients to deny, overlook and ignore many symptoms for the fear of shame (CDC 2013). Therefore, mapping causes and sources of stigma would enable each society to fight it (CDC 2013). However, it was not known whether stigma of mental illness is one of the influences on nurses' perceptions about this specialty in Egypt.

The researcher in the current study did not hold any expectations regarding the results that might come from the focus groups and was not sure whether stigma would be mentioned as one of the factors that influence participants' views about MHN. Therefore, it was decided not to mention the word "stigma" within the questions prepared for the interview guide or to manipulate or lead

the discussions towards the concept of stigma. The main aim was to explore the factors affecting perceptions of MHN and address details of these factors. Examples of questions that were developed to address these points are:

- What would be the factors that discourage participants from working as MHN
- What would be the factors that affect society's perception of MHN
- How do others' opinions affect your perception of MHN
- Can you describe your opinion regarding how the society evaluates MHN

(The Final interview Guide: Appendix 1)

3.7 Role of the researcher in qualitative research:

Creswell (2014) highlights significant responsibilities in the role of qualitative researcher. This role is not limited to the planning stage or data collection process, but involves each step of the study. The researcher needs to be aware of the different subjective realities addressed by participants and of how the researcher's own background might influence data interpretation (Creswell 2014). In this study, the researcher was responsible for all the planning, implementation and evaluation process as well as audiotaping and transcribing each interview.

Researcher reflexivity is another issue to be considered within qualitative research (Hesse-Biber and Leavy 2011, Doody et al 2013, Smith and Bowers-Brown 2010, Creswell 2014). Reflexivity relates to the researcher's stance and nature of expected knowledge, and theoretical background. It is also about how previous experiences or cultural background might affect the process of qualitative research and data interpretation. Therefore, the researcher needs to be aware of personal beliefs and the possibility of personal bias that might affect any stage of the research (Kevern and Webb 2001, Creswell 2014 and Doody et al 2013).

During the current study, the researcher had to be aware of and to analyse her own beliefs and opinions regarding mental health nursing practice. The

researcher had taught at the school of nursing for more than 6 years and is still connected with the school for volunteer work. This enabled the researcher to be connected with the students and to have an idea about possible challenges within MHN and mental health training. Also the researcher had supervised students' mental health clinical placement during her work at the British University in Egypt. From both working experiences, the researcher faced many positive and negative situations with patients and nurses within mental health hospitals and developed her own perceptions regarding the quality of care, patient rights, nursing shortage, economic effects on care facilities. Yet, the researchers' experiences and ideas do not constitute a complete picture of current students' perceptions of MHN. However, awareness of the researcher's own stance, beliefs and accumulated knowledge in the field will decrease personal bias during the data interpretation stage. The researcher is aware also that her own views of the field are only one side of the truth and are not necessarily the same as the students' views. Therefore, the researcher adopted a neutral position during discussions and did not express personal opinions during students' discussions.

3.7.1 The researcher's position and relationship with participants

The study took place at the school of nursing, Cairo University where the researcher had worked several years before. However, the researcher had not worked at the school of nursing during the last 5 years except for some volunteer teaching sessions within the dementia awareness initiative that took place at different places in Cairo. Also the researcher did not have an official position within the school of nursing and was not involved in any kind of student evaluation or examination. Therefore, the researcher had to introduce herself and explain her knowledge and work background to students during the introduction and briefing meetings about the research that took place at the school for the fourth and fifth year students. The researcher explained her position, aims of the research and clarified, at the beginning of each focus group, that she was not involved in evaluations or examinations for each group of students.

The relationship between researcher and participants is an important consideration that needs to be clarified during research; it represents a significant asset for obtaining rich data but is also an aspect for ethical attention (Guillemin and Heggen 2009). Qualitative research depends mainly on good relationship between researcher and participants to develop and maintain a sense of trust and a safe zone for participants to express their opinions and thoughts (Yin 2011, Guillemin and Heggen 2009, Gill et al 2008). Some argue that interviewing people whom they do not know is easier since participants express feelings, experiences and emotions more freely (Braun and Clarke 2013). However, Braun and Clarke (2013) suggest also that it could be easier to establish rapport with familiar people whom the researcher already knows (Braun and Clarke 2013). In the current study, the researcher expected to face some challenges in building rapport with participants since they did not know each other. The researcher expected that some participants could be reluctant to express their opinions and share their stories about mental health nursing. However, this factor did not seem to influence the students and did not represent a challenge during focus groups. Furthermore, students were very motivated to express their opinions and share their experiences of the research topic and rich data were obtained from the different focus groups. Further evidence emerged that a safe atmosphere was maintained during focus groups when after the first two focus groups in the school of nursing, many students started to express their willingness to participate in the research and were interested to share their opinions regarding MHN. This sense of willingness and enthusiasm in the research topic extended until the end of the project at the school and until the last day for focus groups. More students came to the researcher expressing a wish to engage in the discussions and participate in the research. The researcher expected that this could be due to positive feedback shared among the students about the flow of discussion and safety in expressing opinions.

3.8 The Pilot stage: An insight into qualitative research management

The first focus group took place at the faculty of nursing in the MTI where the fourth year constitutes less than 20 students. It was intended to consider this phase as a pilot to test the field, recognize strengths, limitations and

adequacy of planned preparations (Creswell 2014, Davies 2010, Daniel and Turner 2010). Piloting the interview questions is vital for qualitative research studies since it aims to ensure that questions asked will inform the study purposes (Nagle and Williams 2011).

After presenting the study aims and scope to fourth year students through a brief presentation and interactive discussion to answer all student queries, three students agreed to participate in the focus group. At this stage, no recording was used and data were written as a summary by the researcher after finishing the focus group. Also there was no written interview guide. Although this focus group provided informative data and insight regarding participants' perception about MHN, many issues were not given consideration during this interview. One of these issues was the need to record the focus group, because writing a summary of the discussion required exhaustive mental effort to remember who said what and the sequence of information. Also the researcher felt the crucial need to record some nonverbal expressions of participants. Therefore, this stage required review of the literature to understand the qualitative data recording and analysis process. It was found that discussion was interrupted more than once by other topics that students want to raise and talk about during this interview. For example, students started to reveal their anger about the conditions of one mental health hospital, where their clinical placement took place, and referred to the unstable political situation that caused more deterioration to patients' living conditions and resources. Some parts of the discussion were irrelevant to the research topic and it was challenging for the researcher to keep participants focused on the research questions at some points. Furthermore, one of the participants, a student from Nigeria who was very motivated to participate in the discussion, started to explain the MHN situation in her country that seemed very similar to Cairo. At this stage, the researcher realised that there is a strong need to write down the questions for the interview to guide the focus of discussion, to find a facilitative way of having control over participants' interruptions, and to keep track of conversation. Also it was important to consider Egyptian nationality is one of the inclusion criteria during sample recruitment. Therefore, this focus group as a pilot uncovered many issues to be considered with the subsequent focus groups. Also, as

important knowledge was presented by participants in the pilot study, data obtained from the pilot interview are included within study results (Davies 2010).

Data analysis for this focus group was a challenge since the summary written by the researcher was short and no field notes were recorded. Most of participants' opinions during this pilot focus group concentrated around the society's stigmatising of mental illness and workers in the field and the weak role of MHN. Therefore, those two issues were considered during development of the interview guide for the main study. Also it was planned to use recording for all the next focus groups. The researcher also reviewed focus group facilitation strategies and data analysis measures for qualitative studies to be able to moderate next focus groups and overcome challenges faced in the pilot study.

3.9 The main study: running and recording the focus group discussion

Running each focus group was achieved using four phases of transition: introductory phase, transition phase, key question phase and closing phase (Hennink et al 2014). The researcher did not start the discussion by asking participants questions related to the research aim (Freitas et al 1998, Flick 2014). Instead, each focus group started with the introductory phase where researcher had to introduce herself again to the students, introduce the research topic and allow participants to introduce themselves and ask any questions they wanted clarification about. The introductory phase was a chance also to emphasise the ground rules and reassure participants about their rights and protection of their anonymity during recording and transcribing data. The introductory phase included some open ended questions to engage participants in sharing their knowledge. Questions in the introductory phase were such as 'describing their previous experiences of visiting mental health hospitals, nursing patients suffering from mental health problems and whether students had clinical placement at mental health facilities'. In most focus groups, the researcher had to control the length of introductory phase and move to the transition stage after ensuring that participants had the information they required, usually it was a motivating stage for participants. In

the transition phase I had to transfer to the research topic and start asking questions related to the research aim. Transition stage is followed by the key questions phase where the core questions planned in the interview guide are asked and the research question is addressed. At this stage, participants are asked to describe their experience of working with patients suffering from mental illness or explaining their perception about MHN. The final closing stage of the focus group discussion was divided into two main sections. The first one summarised what participants had said and asked if any participant want to add more information. The second thanked participants, appreciating their contribution to the study and answering any questions they needed to ask. At the final stage most participants were concerned about the consequences of the research results and always asked if this research could lead to starting a specialty in mental health nursing at the school of nursing. Developing the curriculum to address more topics about psychiatric nursing was a common comment at the end stage of a focus group.

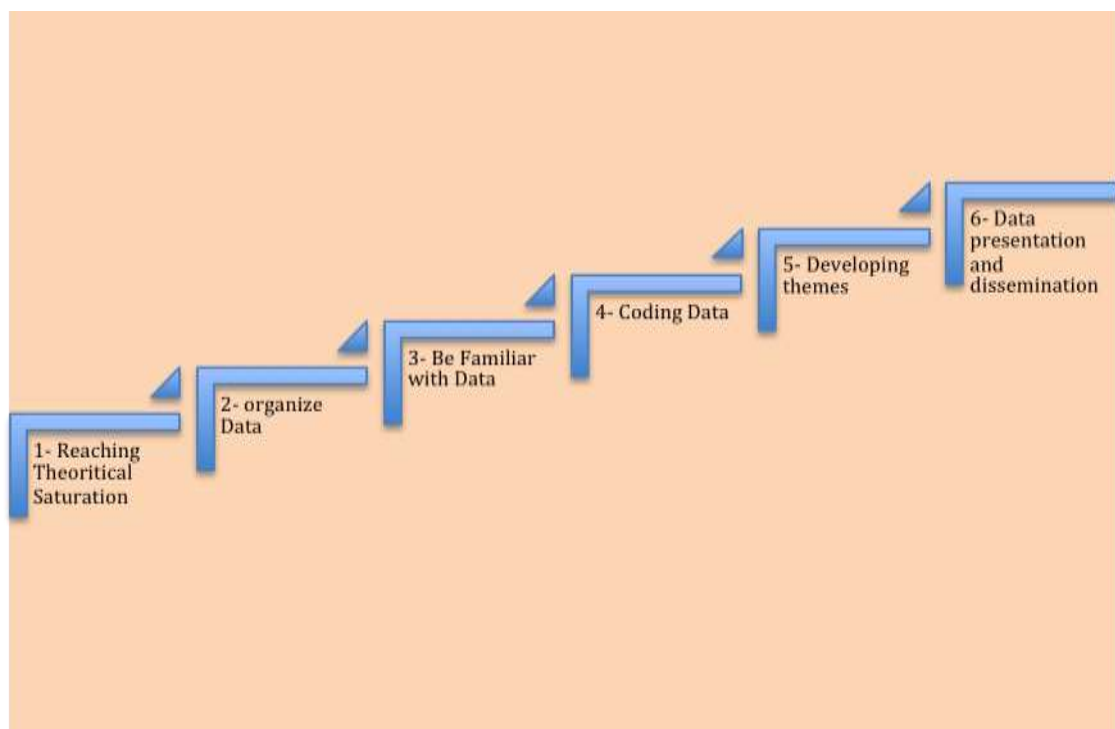
The literature on facilitating focus group interview and data analysis suggests that it is valuable to audio record interviews (Barbour and Kitzinger 1999, Stewart et al 2007, Vaughn et al 1996, Silverman 2009). Advantages of audio recording include the availability of data that can be referred to anytime for robust interpretation, and it frees the researcher to concentrate on the discussion moderation of group interaction (Davies 2010). Use of audio recording also ensures the trustworthiness and authenticity of data, when the participants' own words are transcribed and written accurately (Holloway and Wheeler 2013).

Stewart et al (2007) explained that when the researcher intends to use audio recording, then the presence of audio recording material has to be acknowledged to participants. Audio recording might cause anxiety and hinder the flow of conversations (Davies 2010). Also Stewart et al (2007) point out that one disadvantage of recording is that participants may be reluctant to express their opinion. This rarely happened during the focus groups. However, some students seemed worried at the beginning about the presence of audio recording and started to question why it was needed. The

researcher emphasised the issue of anonymity and confidentiality to reassure students and explained the value of recording for transcribing the exact opinions expressed by participants. There was no noticeable negative effect during the study. Once the discussion started, students engaged in fluent conversation. As recording does not capture facial expressions and body language (Davies et al 2010), the researcher used written notes related to nonverbal communication and group interactions.

Technical failures of recording were avoided through checking batteries and chargers prior to the interview, listening to the recordings immediately after the interview and ensuring that sufficient memory space was available (Davies 2010). No technical problems occurred during the interviews except for the noise that was audible at times in recordings, because of the busy atmosphere and large numbers at the school of nursing.

3.10 Data analysis strategy (content analysis):



Steps of Data analysis & Interpretation- adapted from (Creswell 2014)

To guarantee trustworthiness and credibility of data, transcription of each audiotape was scheduled immediately after the focus group (same day or one

day after the interview). Also, field notes were documented during the interview and immediately after each focus group to reflect the details of interactions and non-verbal communication, and responses to questions throughout the interview. Also, each transcript was read many times before starting the coding and deciding themes for each transcript (Kristiansen et al 2010). This is to familiarise the researcher with the type of data obtained and to allow thinking about suitable codes, themes and subthemes for each opinion expressed by participants. Validity of qualitative data analysis depends mainly on the objective translation of the different subjective realities reflected by participants (Willing 2013, Creswell 2014).

The following part outlines the stages of qualitative data analysis and how the research data were treated and interpreted.

3.11 Steps for data analysis:

- 1- Theoretical saturation & focus group: Saturation occurs when new data are not generated and the same findings reoccur. At this stage, the researcher ends the data collection process and starts to interpret it. An example of similar research that used focus group as a method to describe mental health workers' perceptions was conducted by Kristiansen et al (2010) who used three focus groups and highlighted the issue of theoretical saturation that appears when data start to be similar.
- 2- Organisation of data obtained from the interviews. This includes putting together all the transcripts, audio records, field notes, mind maps that were developed each interview each day, then combined.
- 3- Becoming familiar with data through reading the transcripts and listening to the tapes more than once. This helps to develop a sense of appreciation of the knowledge obtained, the depth of the data, and to obtain a general impression of the main ideas expressed by participants during the discussions.

- 4- Coding for data interpretation where a word or a phrase is chosen to represent each sentence of the transcript. Developing a code for each sentence that reflects its meaning requires critical thinking.
- 5- Collecting together similar codes to develop themes or categories for each group of similar codes follows. Themes should represent the answer to the research question and findings of the study. At this stage selectivity is important to keep the track of what the research question is about and what will represent an answer to it. Usually transcripts include more data other than that related to the study aim. Themes are usually presented with quotes from participants that support each theme and convey the meaning.
- 6- Presenting an interpretation of the study findings highlighting the main results, interpretations, and conclusions. This might include generating new questions and topics to be researched. The researcher should present a critical discussion of the research process examining lessons learned from the study process. Comparing results with theoretical literature is important at this stage to evaluate congruency of research results and to identify areas of new knowledge. Translating research results into knowledge through dissemination via publications is a significant responsibility of the researcher. The added value of knowledge that research presents should appear at this stage.

(Creswell 2014)

3.11.1 Reporting on data analysis stage:

The data analysis stage took place immediately after each focus group. It started with listening to the audio recording of the discussions more than a time then started the transcription for each part of the discussion. Discussions run in Arabic and transcription was conducted in Arabic then translated into English language. At this stage, it required some assistance from an Arabic speaking colleague who used to do a back translation for each transcript. Then we had to review each transcript together and check that translation of each transcript is congruent exactly with what had been said by participants. Management of data was a challenge since each focus group discussion

required from 8 to 10 hours for Arabic transcription, then English translation and back translation took around two more days for each audiotape. During the initial 2 focus groups, the researcher used to listen to the recording of each discussion several times and develop a map with some key words that was repetitive and influencing the discussion. An example of this map is found on (Appendix 7). The map was developed with assistance from the same colleague who helped with the translation and back translation. Listening to the audiotapes and being familiar with the information generated was important for two different reasons. The first reason is to observe the pattern if participants repeat some key words or specific meanings to be highlighted as potential theme (Braun and Clarke, 2006). The second reason was the insight added to the researcher about the flow of discussion, moderation and facilitation skills and how to improve it next time.

By the end of the 8 focus groups, the researcher had to manage considerable amount of qualitative data and find a code for each related sentence expressed by participants. Therefore a framework (Appendix 8) that included a total of 253 relevant sentences was developed and the researcher had to think of suitable code for each sentence. At this stage triangulation was required to decide the final codes and potential themes for each group of data away from any subjective interpretation or judgment by the researcher.

Therefore, the researcher shared a framework (Appendix 8) that included generated data with the supervisory team and extensive discussion and debate meant some amendments were made to the codes gathered data.

The final number of codes that covered generated data was 52 codes.

Thinking of themes was parallel to this process but it was finalized after final amendments of the codes that came up with 4 main themes as the umbrella that will include all the codes as clarified in (Appendix 9). Each group of codes required a theme to be the umbrella of these codes. Therefore the framework (Appendix 9) was developed to include all the codes and themes that could cover it. Verification of the codes and themes by a critical companion who was also a nurse researcher in Egypt was undertaken to ensure the credibility of data and avoid any subjective bias arising from the researcher's opinion.

The final decision regarding themes was amended to two main themes and each one include three subthemes as clarified in (Appendix 10) following

explanation and discussion of the feedback from the supervisory team The following chapter will report on themes generated from the study with examples of quotes from participants.

CHAPTER 4

Study Findings and Results

Overview:

Study sample and data collection
<p>Participants: 4th and 5th year nursing students who had completed the programme of study and were awaiting graduation. Students' age ranged between 17 to 19 years. All students at the school of nursing are female.</p> <p>Method of data collection: 8 focus groups were conducted with 32 participants</p> <p>Place of meetings: school of nursing premises, Cairo University</p>
Themes of nursing students' perception of Mental Health Nursing
<p><u>Theme one:</u> Stigma and Mental Health Nursing</p> <p>Sub-theme (1)- Fear and the concept of stigma among student nurses</p> <p>Sub-Theme (2)- Stigma and organisational behaviour of mental health professional carers</p> <p>Sub-theme (3)- Stigma and the influence of culture</p> <p><u>Theme two-</u> The Challenge of lack of a structured curriculum for mental health nursing</p> <p>Subtheme (1) Training deficiency and distorted perceptions of MHN</p> <p>Subtheme (2) ECT as a factor influencing perceptions of MHN</p> <p>Sub-theme (3) Lack of communication skills</p>
Summary of new knowledge added by this study
<p>Many participants expressed their apprehension about working as a MHN. The perception that mental patients are violent and potentially aggressive was a source of fear and concern.</p> <p>Other sources of fear within MHN were related to risk of addiction sometimes, and the cruel organisational behaviour among MHN staff.</p> <p>MHN was perceived as a highly responsible job in relation to protecting patients' life and safety - suicide and potential aggression between patients. Participants perceived lack of security and of protective support measures in MHN.</p>

<p>Some participants perceived MHN as having low employability opportunities.</p> <p>Gender issue appeared - MHN was regarded as a male job.</p> <p>A few participants expressed that they were not concerned about society's stigmatising view of mental illness and did not consider that the MHN role was stigmatised</p> <p>All participants expressed the need for more educational preparation and clinical training to enable them to work as MHN</p>
Further research
<p>Further research is required regarding</p> <ul style="list-style-type: none"> - Educational preparation for specialised MHN in Egypt - Security and support systems for mental health facilities in Egypt - The ECT stigma among student nurses - The experiences and perceptions of patients at mental health facilities themselves

4.1 Introduction: Input from students' perceptions regarding MHN

Review and critical analysis of the study's transcripts revealed two main themes from the focus group discussions. These two themes are: first, stigma which included different underpinning subthemes, and second the challenge of lack of a structured curriculum for mental health nursing. The following part presents and explores the two themes and connected sub-themes, illustrated in examples of quotes from participants. A section will follow on the new knowledge generated from the study.

4.2 Theme one: Stigma and Mental Health Nursing

During the eight focus groups conducted in Cairo, many participants pointed to the issue of stigma on different occasions and with many examples. Stigma was at the centre of discussions raised by participants. Among 253 of the related sentences from the data analysis transcripts, there were 64 sentences that related to stigma in different ways. Participants referred to stigma from different perspectives such as:

- Stigma associated with mental illness and the Egyptian society's perception of it
- Stigma related to the perception that mental patients are violent and dangerous
- Stigma associated with seeking mental health services
- Stigma associated with ECT
- Stigma of working as a nurse in Egypt

Stigma was associated with three subthemes. These subthemes are

- Fear
- Organisational behaviour of mental health care providers
- Cultural influence

The following part will present the concept of stigma as it reflects the Egyptian culture illustrating the meaning of '*stigma and mental illness*'.

Mapping sources and causes of mental illness stigma is a key to enable each society to fight stigma (CDC 2013). In terms of components of stigma, Schumacher et al (2003) provide a review on stigma associated with mental illness, concluding that it can be manifested in three ways, through stereotype, prejudice and discrimination. One of the main stereotypes about mental illness stigma is that potential violence and aggressive behavior might occur from patients (Rueve and Welton 2008, Halter 2008, Hunter et al 2014, Sercu et al 2015). Although Rueve and Welton (2008) identified causes and possible management for patients' aggression, yet, it is still considered a main source of stigma to both patients and health care workers. Therefore, sentences related to patients' violence, potential aggression and staff safety would be considered under the umbrella of Theme One: Stigma & Mental Health Nursing.

The next part illustrates findings associated with fear, the first subtheme related to the concept of stigma.

4.2.1 Sub-theme (1) Fear and the concept of stigma among student nurses

Fear is the first subtheme relating to stigma as it appeared from participants' views within the transcript. Students expressed their fear at different instances during the discussions. Fear took three main forms:

Main sources of fear within MHN

- Fear of patients (patients can be potentially violent physically or verbally)
- Fear about patients (patients might commit suicide or hurt each other)
- Fear of the unknown (ECT, nurses' addiction, lacking organizational support, expected workload)

4.2.1.1 Fear of patients - patients are potentially violent

Among all the focus groups, the issue of potentially violent behaviour from patients was voiced extensively within all discussions. The belief that patients who suffer from mental disturbances are potentially violent verbally or physically was one of the main issues during discussions and a significant factor keeping students away from MHN. This opinion was shared by both students who had experience with MHN during work or clinical placement and among students who did not have any experience of work and clinical placement. Analysing participants' perceptions revealed that even those participants who had a positive opinion of MHN and considered it an important specialty among different nursing branches, still believed that they could be subjected to harassment and aggression.

"I'm worried most of the time from any aggressive situation that can happen from patients, sometimes patients are dangerous (G1-P2)"

"I believe my own safety will be in danger (G3-P1 & P2)"

Some participants went further, labelling a specific group of patients such as patients who suffer from schizophrenia.

“People usually either afraid of them or trying to help them but don’t know how...I mean ...particularly schizophrenic patients are not welcomed among people (G3-P1)”.

Labelling patients and differentiating between different categories of patients was an issue to consider from the participants’ view.

Literature differentiates between two main categories of mental patients on the basis of who is perceived to be dangerous and who is perceived to be blessed (Coker 2005). Cooker clarified this issue with relevance to Egyptian culture. (Coker 2005) described Egyptian culture as rejecting patients who suffer from unaccepted behaviour or loss of self-control and tolerating patients who suffer from disturbances such as learning disability. Cooker’s opinion presents an explanation of the social shame that exists in Egypt and shadows mental health diagnosis. El-Krenawi et al (2000) emphasized the same point and stressed that stigma does not exist with disturbances such as learning disability. Although none of the previous literature related to research with nurses, results from this study show that many nurses’ opinions are not so different. Comparing these opinions with non-Egyptian literature, a research study from USA (Schumacher et al 200) was conducted with 117 participants to describe their perceptions regarding mental illness stigma. Schumacher et al (2003) asserted that positive symptoms of mental illness and bizarre behavior are significantly associated with stigma and social avoidance of a person. Therefore, it could be concluded that literature evidence asserts that positive symptoms, of potential patient aggression and fear are consistent sources of stigma related to mental illness. The current study participants also expressed these sources of stigma extensively, which reflects that stigma relates to the Egyptian culture, and to other societies.

Some participants who had not been to mental health clinical placement based their fear on situations that happened with their colleagues such as:

“...but one of our colleagues was attacked by a psychiatric patient during her work at the orthopedic department, she was verbally insulted and she felt so embarrassed and was not able to work with this patient, so what will happen if I went to work at a psychiatric hospital...(G4-P1)”

This situation was one of the main issues that prompted discussion within this group. It suggests that avoiding MHN as a career is not the solution to avoiding the potential violence of patients, because nurses at general hospitals also meet patients suffering from psychiatric disturbances in various departments. Consequently, avoidance of patients themselves can be the safe option as implied in the discussion. This point will be critically considered in the discussion chapter. Moreover, some participants did have experience of working in a mental health facility and believed that it was not very safe to work as MHN:

“I worked at a psychiatric hospital for 9 months and liked the experience, yet sometimes the patient becomes aggressive to the extent that he can harm himself or the medical team.. It’s scary sometimes (G7-P1)”

Fear of patients who suffer from psychiatric disorders is not limited to the Egyptian student nurses. This is acknowledged in the connection between some tragic accidents and mental illness (Fitzpatrick 2015). Fitzpatrick used the example of the young pilot who crashed his plane on purpose in the Alps and killed everyone on board by committing suicide. Such accidents influence empathy with the patient who tries to hide his illness to avoid any difficulties he might face (Fitzpatrick 2015). Yet, Fitzpatrick (2015) tried to defend patients, highlighting the suffering they experience, when he explained that many patients are subject to discrimination and deprivation from basic health services due to the stigma of mental illness.

Returning to the Egyptian perspective in the current study, a lack of empathy was expressed occasionally by some participants who seemed to doubt that the illness is the cause of aggressive behaviour and appeared to think that some patients are aware of their actions such as:

"..... I mean...they might be aware of what they are doing...and who will defend me in front of this danger ,,,, in general hospitals for example you can find people are not responsible for their actions due to coma and other health issues but MH is different they might be dangerous ...(G4-P1)

Accusing patients of awareness of their actions sometimes has an echo in different situations that revealed this hidden conviction among some participants. From another standpoint, an alarming truth revealed in the Mental Health Myths and Facts (2015) is that mental patients are 10 times more susceptible to be victims of violence and that only 3-5% of psychiatric patients might commit a violent act. The discrepancy between participants' beliefs and the literature evidence could be related to the personal experiences and situations experienced by each person. In summary, the contradiction between perceptions of people to mental illness patients and the reality of patients' lives does exist and should be condemned. However, many participants did not support this opinion during discussions. The sense of fear and lack of safety extends to the inadequate safety measures and staff support procedures in many mental health facilities as expressed in the following quotes:

".... the problem is related to risk factors and lack of safety in the hospitals.... but the society's view to MHN is not important to me ...(G4-P1)"

"..... if I only can guarantee X Psychiatric hospital is a safe place and I will work in a safe environment , I will go to work there (G4-P3)"

This fear was one of the main reasons that kept student nurses away from MHN as a field of specialty or a career choice:

"Nurses become in danger if they worked in this field...and susceptible to violence (G5-P2)"

“I know that MHN has many positive sides yet, we are susceptible to risks such as assault verbally and physically, unfortunately can not choose it as a career choice (G6-P3)”

This fear and avoidance of working as a MHN is not limited to Egypt and extends to various places in the world. This will be discussed further in the next chapter.

4.2.1.2 Fear about patients

Fear took another perspective when some participants began to shift the discussion away from nurses' own safety towards thinking of patients' own safety. Some participants said that they were worried about patients and possible measures to protect them:

“..... also aggressive violence situations, patients might harm each other!! (G3-P3)”

It seemed that students were aware of some issues inside mental hospitals in Egypt that constitute a major part of the challenge, for example the systematic abuse of patients. Patient violence to each other is well recognised and acknowledged specially at governmental psychiatric hospitals where bruises and skin discolouration due to physical aggression are common, as witnessed by the researcher. Articles such as El Shazly's (2015) pointed to the issue of physical abuse and deprivation from treatment that might be practised by nurses in psychiatric hospitals. The issue of mental patients' security at mental hospitals was raised widely during the summer months. The tragic death of 11 patients at the same hospital in the same week raised many concerns in the press, since the cause of death was linked to the heat wave (Daily News Egypt 2015).

Another source of fear about patients is fear of patient suicide. Some participants stated that suicide is their main concern regarding fear about patients and patients' safety. Suicide is considered a major sin among the Muslim and Christian society in Egypt and usually is associated with police

investigations due to considering suicide as a criminal act (Endrawes et al 2007). This could be adding to students' fear and anxieties about being involved in any criminal accusations if they failed to protect the patient. Suicide is a real fear for some participants who put safeguarding patient's safety as a priority:

"I'm afraid about suicidal patients.... suppose that he harmed himself while I'm busy with another patient...I will not forgive myself (G3-P1)"

Another participant expressed that suicide and patient's safety are concerns for her, yet the fear of responsibility was also acknowledged.

"Yes Suicide is really a danger and a responsibility for MHN, nurses carry all the mistakes at the end (G3-P2)".

From a different perspective, one of the participants made a connection between education and nurses' skills of observation, assessment abilities and the ability to protect the patient:

"Also nurses lack the observation skills,,, such as the signs that indicates suicide...patient doesn't suicide suddenly.....the nurse should observe ...(G2-P1)"

This opinion reflects the importance of enhancing nurses' skills and knowledge for MHN and was agreed by other participants.

One of the participants in another group expressed that risks such as suicide could only be prevented if nurses can understand and help:

"In MHN we are able to help many people and prevent risks such as suicide and aggression, MHN is very important (G6-P2)

However, this opinion was not supported by rest of the group.

In summary, there are two sources of fear about patients admitted to psychiatric hospitals. First, the fear from physical aggression between patients and each other that puts responsibility on nurses to protect the patients. The second is fear about patients from suicide. This issue also seems to influence their perception about MHN i.e. that it is important in preventing /reducing the risk of suicide.

4.2.1.3 Contrasting opinions about a MHN career

Although the majority of students raised the issue of fear of patients' behaviour that might present as physical or verbal assault to the nursing team, some participants presented different views and disagreed. During most focus groups, discussions took place where some agreed about an opinion and some rejected it. This suggests that there was no domination by a specific opinion or by specific participants over others and that opinions were expressed freely and spontaneously. This is what happened with the issue of fear and the possibility of violence where some students rejected the idea and tried to express the opposite opinion:

"I don't agree that MHN is the worst specialty...there is a risk within all nursing duties...(G4-P2)"

This quote came as a reply to another participant who expressed her anxieties regarding risks associated with MHN and clarified that mental patients can kill and that they are not responsible for their actions. G2-P2 tried to express the opposite opinion through an extensive explanation about the dangerous infections and complications that nurses are exposed to within all nursing specialties. Yet, she put herself under attack from other participants in the discussion and her opinion was not convincing to the rest of the group who insisted that MHN is the worst among nursing branches. Again the voice of empathy and positivity was rarely heard within different groups:

"The patient needs someone to listen to him...someone to understand his suffering, who can make him calm....just be with them (G3-P1)".

“MHN is important and unique as well rather than medical and surgical specialties, and it is different in terms of communication with patients (G3-P2,3).

However, the debate within this group changed to doubt about educational preparation and confidence needed by participants to work as MHN:

“Most of the topics we studied are theoretical content ,,,not sure about clinical (G3-P4)”

“I think nurses should be able to work in all specialties..... including MHN.. we might meet psychiatric patients anywhere in our life or at general hospitals as well (G8-P1)” .

Again this was an independent opinion within this discussion and was not supported by other participants. This will be critically analyzed during the discussion chapter. Some participants did not express a direct negative opinion about MHN and started to compare MHN with other specialties that might be easier:

“.... other specialties such as internal medicine and pediatric are easier for nurses than MHN (G8-P4)”.

This opinion would suggest that some nurses regard working as a psychiatric nurse as a difficult task, perceiving other specialties such as internal medicine to be better supported and less stressful.

4.2.1.4 MHN and fear of addiction among nurses

Some unexpected knowledge was gained during discussion with participants who had experience of working for short periods of time within a psychiatric hospital. Addiction and drug misuse by nurses was one of the surprising issues to be raised by few students. The risk of drug addiction was a source of fear for participants, who were aware of different cases of MHN or general nurses who took drugs to be able to work more hours and became addicts.

“I have a different opinion.... when I went to the psychiatric clinical placement I worked at the addiction department and found many nurses who become addicts.. they used to take addictive drugs to work more hours and they end up at the psychiatric department...I felt I might be like them... so decided not to go again there (G6-P3)”

“ I witnessed 3 psychiatric nurses who become addicts and don’t want to enter this field (G6-P5)”

This is a hidden issue not widely explored in literature, although it seems to be happening in various places with different nursing specialties. The problem of drug misuse among some nurses is complicated and cannot be justified due to workload and difficult economic conditions that urge people to work more hours. The view that an easy solution is through taking drugs, and the fact that drugs are available to nurses, are issues that require further research. The views expressed by participants reflect few nurses’ perceptions regarding MHN that raise many questions about the effect of drug misuse on nurses’ behaviour. They also raise concerns about health and safety procedures that affect nurses’ work and should be introduced.

4.2.1.5 Summary of stigma related to fear

Many nurses consider patients who suffer from mental disorders as potentially violent and that their safety is at risk. Students or their colleagues within MHN base these fears and anxieties on incidents that they experienced. MHN as a career choice is affected by these fears and anxieties that stigmatise patients and label them as a potential source of assault. Students said that lack of safety measures and staff support had been witnessed at different mental health facilities. Few participants expressed their willingness to choose MHN as a career choice and they noted that nurses will meet patients suffering from mental health issues in different departments and in general hospitals. It was suggested that basic knowledge is required for all nurses about mental health.

4.2.2 Sub-Theme (2)- Stigma and organisational behaviour of mental health carers

Organisational behaviour of mental health carers is a theme raised by participants on multiple occasions and through different examples. This theme was manifest in two major ideas: lack of positive role models due to staff negative behaviour at mental health; and the use of power over patients. The argument that took place around lack of role models and the inappropriate use of power by psychiatric nurses was one of the strongest matters that influenced participants' perception about MHN and their opinions about MHN as a career choice. This will be explained in detail in the following part.

4.2.2.1 Lack of positive role models within psychiatric nursing:

The majority of participants within different groups expressed their rejection of nurses' behaviour at mental health facilities. This opinion was very strong and apparent and contrasts with the kindness and compassion that nurses should be adopting. Participants who had experience of work or training at mental health placement raised this opinion as a negative issue. This happened within most of focus group discussions. Furthermore, participants who did not have mental health placement or work experience also held this opinion. Many participants expressed their refusal to work as MHN due to the unprofessional MHN practice they witnessed:

“After I saw psychiatric nurses, I decided not to work at this field (G6-P3)”

Another participant voiced her anger towards MHN after she had work experience in one of the psychiatric hospitals. She identified that this specialty lacked role modelling:

“I don't like to be part of this nursing, I mean MHN ..., I didn't find a role model to follow in psychiatry (G6-P2)”

“The communication between health team was aggressive and loud, I liked staying with the patients but from another point, I didn’t like to be part of this aggressive team, communication was really bad. (G1-P2)”

Participants’ expressions about negative workplace culture within psychiatry were spontaneous. Mental health nurses’ negative behaviour was a significant factor influencing participants’ perceptions about MHN and this was revealed through different incidents. For example, one of the participants stated that she adopted aggressive behavior, thinking it was the only way to communicate. She was not satisfied with her way of communicating with patients. She just copied what others around her did at the hospital:

“ I noticed my self screaming and shouting at patients like nurses in the department when I worked at psychiatry.... didn’t like my behavior ...I just copied what other nurses do and thought this is the only way of communication there (G6-P4)”

It was apparent here that participants lacked a role model during their work and were trying to express their own anger and dissatisfaction due to copying unprofessional practice. Yet, negative experiences might not necessarily mean rejection of a MHN career. It could be that if participants had a chance to train at a good place with a supportive team and positive role models, opinions might be different. However, positive role modelling along with supportive senior staff and quality of work place are key factors that shape MHN experience and may influence career choice (Cleary et al 2012).

An opposite opinion was given by one participant in response to the issue of staff negativity. This participant described her positive experience with staff when she worked in a mental health facility albeit in a difficult work environment that lacked facilities. The issue that made her experience positive with staff was the helpful attitude from doctors who explained new diagnoses and introduced patients’ condition to new staff. This kind of support and help to develop knowledge was a significant source of positive relationships within the team:

"I found some doctors who explained to us the different diagnosis and supported us at many situation (G6-P1)".

Hence, it can be concluded that positive experiences with colleagues and gaining knowledge about patients' diagnoses and how to deal with them, are sources of reassurance. However, very few participants had such an experience.

The issue of need for a role model recurred, expressed by participants in different groups. Participants hoped for role models who could guide them and who they could shadow to become MHN. This suggests that MHN is not totally rejected, but issues such as role modelling and mentoring are required to motivate student nurses to adopt MHN as a career choice:

"regarding MHN....we need a role model...someone to shadow and follow then we might decide to join this field or not....(G2-P2)

"I wish there was a role model that I can follow, I believe abroad nurses do patient assessment and can diagnose as well and are appreciated, I wish we become like this one day (G1-P3)"

4.2.2.2 Restricting patients' freedom and using power in psychiatric nursing

Another concern that influenced participants' perceptions of MHN was the inappropriate use of power by psychiatric nurses. This was apparent through the issue of restricting patients' freedom. This was very troubling to many students who did not agree but could not choose alternatives. Restricting patients' freedom was referred to within different group discussions. It seemed to be a taken for granted behaviour by nurses in different places to practice control and power over patients:

“When I went to mental health department at hospital ... I saw negative nursing practice ... nurses shout at patients or ignore them, or just lock them inside, don’t want to be like this (G2-P2)”

“ keeping patient inside all the time make me feel helpless and sad for them..... they deserve better treatment (G7-P4)”

“ I imagined my self kept inside like the patients and insulted by each one in the department.... I hated the whole situation...the practice I saw from nurses at mental health was unacceptable (G6-P3)”

Again the issue of lack of role models and witnessing negative cruel practice was clear to many participants. These quotes not only reflect the sense of rejection and sometimes frustrations of participants due to the negative behaviour in the examples, but they also highlight students’ feeling of responsibility and lack of an advocacy role for patients, even if they do not know what the measures are to activate this role. Participants in these quotes expressed their rejection of nurses’ abusive practice at mental health facilities and expressed their distress and sadness. The students’ perceptions reveal unexpected information regarding negative sides of nursing practice at mental health such as the use of power in psychiatric nursing. Moreover, seclusion and restraints were sources of threat for patients, and nurses also used ECT as a source of threat and punishment:

“I saw many nurses threaten the patients with isolation, ECT, and other methods...they think this is the way to control the patients ...I don’t agree (G8-P1)”

“..also seclusion and using restraints were used frequently...I didn’t feel comfortable with such practice...there are always alternatives (G8-P3)”

Participants tried to clarify their own stance in relation to these practices through refusing to work there and avoiding the situations. It can be suggested that cruelty in the work place is another reason to keep students

away from MHN. Factors leading to such negative practice need to be explored and highlighted in further research.

4.2.2.3 Mental health nursing perceived as a job for men

Some participants raised the gender issue. There was general agreement that MHN is better as a job for men.

“ MHN could be better a male job (G7- P2,P4, P3)”

“ It’s a male job, don’t think we should work at MH as females, I might be in danger and threatening situations... (G4-P1)”

4.2.3 Sub-theme (3) Stigma and the influence of culture: mental health nurses are stigmatised by society:

One of the factors influencing the participants’ perceptions of MHN was the cultural influence of Egyptian society which seemed to stigmatise nurses themselves if they chose to work in Psychiatry. This cultural influence and perceived stigma about psychiatric nursing as a career extends to students’ families which increases the pressure on participants to stay away from this branch of nursing. It will be shown in the next part, that even if participants who have empathy with patients suffering from mental illness decide to think about MHN as a specialty, they will have to face some offensive comments from the society and rejection by their own families. It appeared from the different views of participants that stigma also extends to the members of the health team who work with mental patients.

“People say that mental health nurses are psychologically disturbed as well (G8-P4)” and another opinion supported the same view *“I agree.... the society does stigmatize patients and nurses and usually sees MHN as depressed or disturbed (G8-P2)”*

This opinion was expressed within all focus groups and considered an integral part of student nurses’ perception of MHN. The psychological burden of society’s stigmatisation of MHN was huge and apparent.

“Majority of the society have a negative image about MHN....you deal with the insane,,,,, you are like them” (G3-P4)

“Yes...I agree...many people stigmatise nurses when they work in the field of psychiatry (G3-P3)”

Unfortunately the stigma extends to nurses' own families who put extensive pressure on participants to stay away from mental health as a specialty.

“My family thinks MHN is a dangerous specialty and they don't agree working at it... they believe patients are risky and this specialty is stigmatising (G8-P1)” At this point the whole group agreed. *“My family has the same opinion about MHN... it's dangerous and stigmatising (G8-P2)”*

Clearly, family pressure has a negative effect on MHN as career choice. Family pressure to avoid MHN and the stigma of MHN in Egyptian society are the main issues in participants' perceptions of MHN. Even those who might consider working in MHN think that their decision will be an issue with their families.

“I don't like to work as a MHN but if I thought about it my family will prevent me in my family they would say that I will end up crazy and insane like the patients, the issue is related to the culture which refuse I think this whole issue (G1-P1)”

Facing the stigma of being a nurse in Egypt:

A few participants talked about an unexpected view, that there is a negative image of nursing as a career in Egypt. They thought that there is a stigma to working as a nurse in Egypt since it is one of the careers with a low reputation among Egyptians.

“.... the society considers that nursing is not a respected career (G1-P3)”

However, it seemed that a few participants did not care about the stigma of mental illness or stigma associated with MHN. They believed that choosing to be a nurse means working at different specialties regardless of society's perception.

" the society's view and stigma to MHN is not important to me ...(G4-P1)" and a response to her was *"..... yes, if you work for example at the urology centre, people might be sarcastic also and say the urology nurse came!!, I think who accepts to work as a nurse should be able to work at different specialties (G4-P2)"* and *"that's true, the stigma is related to nursing as a career but this matter will not stop me to choose MHN as a specialty (G4-P3)"*

These views mirror one of the major challenges that prospective nurses have to face and deal with, that is, the society's view of the nursing career in Egypt. Neither participants who support nor participants who reject MHN consider Egyptian society's perception of a nursing career as an influencing factor in perception of MHN. However, society's negative stigmatized image of nursing expressed by participants is causing a sense of frustration to some and encouraging others to ignore society's view about MHN.

4.2.3.1 The 'Mad' label

While literature considers cultural influence as one of the factors that affects perception of mental illness, it was not clear before the study whether this effect extends to nurses. During the focus groups, many participants raised the issue of the Egyptian cultural influence at different levels.

Sometimes participants blamed the society for stigmatising patients who suffer from mental problems.

"...yes, the society sees any patient who seeks medical advice related to psychiatric problem to be mad... this is shameful (G7-P5)"

"The problem is the society who stigmatize it and many become afraid of patients when they know they are psychiatric patients (G3-P2)"

While accusing the Egyptian society of stigmatising patients and labelling them, it can be understood from previous opinions that participants are empathetic with patients and try to reject this negative perception, adopting a more positive and accepting approach. Even participants who preferred not to work as MHN, refused to accept the society's rejection of patients and labelling them as "Mad".

Empathy and compassion expressed by many participants, when they described how the society in Egypt label mental illness, was not reflected in their decision making regarding MHN as a career choice. The sense of fear from patients and lack of the sense of safety expressed by many participants, in addition to lack of family support, were the strongest influences on participants' perceptions of MHN.

4.2.3.2 The 'Do Not Seek Medical Help' dilemma

An indirect effect of stigma and society's rejection of mental illness was reflected in avoidance of seeing medical help and consequently deterioration of patients' health. Although this point does not reflect directly on participants' perceptions of MHN, yet, stigma was potentially a significant source of deterioration of patients' conditions. Reluctance to seek medical help may consequently put more pressure on MHN. Some participants questioned why they should accept this and why patients and families surrender to such sham and societal pressure.

It was felt that seeking medical help would increase the shame and that ignoring the problem was encouraged by society.

"Going to psychiatric doctor and seeking help is very stigmatising and people say this will bring more disturbance...they prefer to ignore the problem than acknowledging it (G8-P2)"

“ Yes..I saw many people when they see a person suffering from depression ..they advise not to go to a doctor... this is the last option to avoid stigma (G8-P3)”

Some participants questioned why MHN should see patients at a very late stage, because their families refuse the idea of treatment. Others explained that talking about mental illness is not an easy task in Egypt.

“Here we don’t seek help until our back is to the wall, I mean we seek medical help when the person can’t live with his illness and when he deteriorates to the level that interrupts his life ” (G1-P1)

“yes, it is not easy to talk about mental health, even depression sometimes is considered a stigma , we tend to hide the problem not solving it, so the nurse will see the patient when he deteriorates not at the early stages.....(G1-P3)”

It appeared that hiding mental illness and avoiding seeking help until the patient’s condition deteriorates not only affects patients and their families but also increases the negative perception that nurses might hold about working in MHN. The opinions of participants also show that both mental illness and its related medical help are linked to stigma, to shame, and to the stereotype of the mental health patient.

4.2.3.3 Sub-theme 3 summary

The society in Egypt does sometimes stigmatize patients suffering from mental illness and their health care providers.

It can be understood that, the society’s stigmatizing attitude towards nursing career and psychiatric nursing is not a concern for some participants. But still the true challenge came from many students’ families who are part of the society and can urge participants to avoid this specialty.

Seeking medical help is widely discouraged by the society regarding mental health; consequently, mental health services and team are not well accepted by the society. Yet, many participants are not concerned with stigma of

working as MHN, they are more concerned about the deterioration of patients' conditions that worsen the situation and render MHN work more difficult.

4.3 Theme two- The challenge of lack of a structured curriculum for mental health nursing

In all the focus groups, all participants expressed their lack of knowledge and skills in MHN. It was clear from participants' opinions, that lack of MHN educational preparation affects students' perception of MHN at different levels. Factors affecting lack of educational preparation included inefficient theoretical content of MHN, inadequate clinical supervision and role modelling within MHN, communication barriers and difficulties with patients, and low self-confidence in working as a MHN.

Recurring statements from participants illustrate the relationship between lack of MHN related knowledge and skills, and a sense of fear and anxiety: *I don't know what to doI'm afraidI don't know about ECT....will not participate.....I'm afraid to torture patients.....I don't know how to activate my advocacy roleI don't know what I should do to communicate with patients.....*

4.3.1 Subtheme (1) Training deficiency and distorted perception about MHN

Attitudes and perceptions towards psychiatric nursing are greatly influenced by the clinical experience students have in this specialty (Dawood 2012). Lacking clinical experience is one of the factors that students expressed as a challenge in relation to having satisfactory experience of MHN and pursuing a MHN career. In many examples, students said that current education was not sufficient to qualify them to work as MHN. They said also that they did not have an opportunity for clinical training in MHN. Even those participants, who were placed in psychiatric wards or clinics, did not have any kind of clinical supervision for this branch.

"We didn't have any MHN clinical training (G3 – All participants)"

“Although we are about to graduate after few days...I don’t believe we had enough education that qualify us to work at MHN...I will lack confidence to work at this field (G5-P4)”

Participants started to express their lack of awareness about their role in MHN and unfamiliarity with the responsibilities of this specialty due to lack of clinical training in psychiatry.

Another issue influencing participants’ perceptions of MHN was the adequacy of theoretical content in the curriculum. Theoretical content was given by a medical doctor not a nurse and there a lack of congruence between knowledge taught in theory and what happens in clinical practice.

“The theoretical part about MHN was superficial and it was taught by a medical doctor not a nurse.. We didn’t have clinical training in this field as well (G5-P3)”

Participants identified that perceptions of MHN and their decision to chose this branch of nursing for their career are mainly formulated at clinical placement.

“If we have enough clinical training, we will work as MHN..... Only lacking clinical training is my problem (G3 – P4)”

“If we have psychiatric clinical training, maybe we will have more confidence to work as MHN (G3, P1, P2)”

Students also felt that there were differences between types of hospital, private and governmental. They believed that private hospitals could provide better training and better conditions for staff and patients.

“Private psychiatric hospitals will take care of patients and consider the workload on nurses, patients at private hospitals are valued and well treated because their families usually follow up with the hospital and pay a lot of money, this is opposite to governmental hospitals (G6-P5)”

Some participants referred to the care patients' families give to them and the well-established hospital facilities in the private mental health sector. This opinion was faced with accepted and agreed.

".... but I think the place of work makes a difference, mental health private hospitals are much better than governmental psychiatric facilities, regarding patient respect and human rights and all facilities (G7-P2)"

"Private psychiatric hospitals are better than governmental but it is very expensive ... (G6-P1)"

4.3.2 Subtheme (2) ECT as a factor influencing perceptions of MHN – lack of knowledge about ECT

It was one of the unexpected aspects of the study results to discover that ECT, and rejection of this procedure, were issues for students when discussing perceptions of MHN. ECT was seen as a vague unexplained procedure. Lack of knowledge about ECT was an issue raised on different occasions. Participants were not sure about the preparation for patients, they lacked basic knowledge about its uses and advantages, and some stated that this procedure should be banned to decrease patient's suffering and pain. Lack of knowledge about ECT was also connected with a sense of fear and anxiety about whether students' should participate, or refuse to participate in this procedure.

ECT is still one of the controversial procedures, sometimes mistakenly presented in the media as a punitive procedure to patients (Kavanagh and McLoughlin 2009, Smith and Gallagher 2011, Payne and Prudic 2009). Students who lacked knowledge about this procedure believed that MHN was challenging due to the difficult situations such as ECT that they might encounter without enough educational preparation.

" ECT is shown in the media as a punishment for patients and I'm really worried from this practice, I still don't have enough information about ECT although I finished the year, so can't decide if it is something accepted and

consider a kind of treatment or not, I have no idea about its advantages and disadvantages (G1-P3)” This opinion was supported by rest of the group

Only one opinion differed, from a participant who believed that ECT treatment could improve a patient’s condition:

“if electro convulsive therapy is useful for the patient.Why not...if it will help (G4-P2)” But her opinion was faced with a storm of rejection by the rest of the group who tried hard to express the opposite view:

During this debate, one participant tried to present a rationale for her opinion noting that lacking knowledge about ECT is an obstacle in determining its usefulness.

It can be concluded that ECT adds to participants’ negative perceptions about MHN. However, nurses’ perceptions and attitudes to ECT are strongly connected with factors such as level of knowledge, the role of education, years of experience and place of work (Gass 1998). Therefore, education and clinical training about the nature of the treatment might help to change this view.

4.3.3 Sub-theme (3) Lack of communication skills

It was clear from participants’ views that mental health nursing education influenced students’ perceptions of MHN. Those participants who considered that learning communication skills for psychiatric nursing was missing from their education raised concerns about working in MHN. Ability to communicate with patients was seen as an essential antecedent for work as a MHN.

Lacking knowledge about communication strategies in psychiatric nursing led many participants to believe MHN would be difficult and challenging work. Other participants considered knowledge as a key for success and asked for it to be included in the curriculum. Participants’ fear and worries can be understood, since communication skills form a cornerstone of psychiatric nursing education (Cleary et al 2012).

“the problem is....if I don’t know how to communicate with the patient I will not be able to work. (G3- P1)”

Other participants highlighted their concern about lacking communication skills for specific diagnoses such as manic depression and schizophrenia and lack of knowledge also influenced participants’ career choice.

“Knowledge is the key for success in MHN... nurses should be aware of different diagnoses and how to communicate with each patient (G8-P4)”

“I was taught signs and symptoms of mania, schizophrenia but didn’t know how to communicate and care for them (G6-P1)”

4.3.4 Summary of theme 2

Many students said that their learning process lacked focus on MHN and this affected their perception of this field of nursing.

On many occasions, students complained about lack of knowledge and confidence regarding the MHN role and its clinical responsibilities, blaming the missing connection between theory and practice.

ECT was related to the mental illness stigma and influenced student perceptions of MHN, since many said that they did not want to participate in this procedure.

Clinical training and addressing psychiatric nursing topics within the school curriculum would help to change the view of MHN and help participants make informed decisions regarding MHN as a career choice.

CHAPTER 5

Discussion and Conclusions

5.1 The study's main findings

5.1.1 Stigma - Fear and avoidance of mental health patients

Fear of patients and their unexpected behaviour was an integral part of student nurses' perception of MHN. This fear and the stigma that patients are potentially violent, and the lack of a sense of safety at mental hospitals, affected prospective nurses' career choice. Also, this sense of fear could affect nurses' future work if they met a patient suffering from mental illness in a general hospital ward. Students usually experience fear, anxiety and uncertainty during psychiatric clinical training, which is considered to be a different type of experience for nurses that might be emotionally distressing (Kameg et al 2009). Therefore, understanding students' perceptions is important to inform possible curriculum changes and to address new knowledge based on students' learning needs.

Schumacher et al (2003) provided a review of stigma associated with mental illness and concluded that it can be manifested in three ways, stereotype, prejudice and discrimination. All three forms of stigma can be manifested in avoiding patients, as Schumacher et al (2003) explain, in connecting the triangle of stigma, fear and avoidance among nursing students. Schumacher et al (2003) assert that if students are afraid and stereotype patients they will stay away from the field of MHN. The current study results support this interpretation, where even those students who have empathy with patients and their conditions said that they hesitate or even refuse to work as a MHN. The main reason behind students' perceptions was fear and stereotype of MH patients. Furthermore, Lethoba et al (2006) explained in her paper that in South Africa, nurses are not separate from their society and they hold similar social prejudice, beliefs and stigma towards mental patients. Schumacher et al (2003) and Lethoba et al (2006) reflect the participants' views shown in the study results regarding fear and avoidance of patients. This suggests the

need to examine sources of fear and anxieties for nursing students in order to overcome them and properly address them in future curriculum changes.

From a Canadian perspective, Gogging's (2010) aim was to stand against the stigma of mental illness that is mirrored by nurses and care providers in society. Gogging (2010) argued that student nurses hold an unrealistic stereotype about mental patients, regarding them as usually violent and likely to attack them. Moreover, Gogging (2010) suggests that patients can be described as victims, since they face offensive comments and blame from nurses and care givers in many situations when they need help and support. Regarding the issue of fear of psychiatric patients, Gogging (2010) stated that during her 30 years of work in mental health nursing education, patients never attacked her. Yet, convincing student nurses that working at mental health facilities is a safe choice and free from dangers requires more than confirmation that it is safe to work as MHN and requires an active role for education and clinical training (Tognazzini et al 2008). Therefore, it could be suggested that, in relation to the concept of stigma within its curriculum, that the nursing school in Cairo might review the clinical placement in psychiatry and that further research could be planned in future to investigate students' support strategies.

Although Gogging (2010) questioned the stereotype that patients are potentially violent and aggressive, in contrast the Health Commission (2005) clarified that around 80% of workers at psychiatric facilities are subject to assault, aggression and threats from patients. This report notes that nearly 80% of nurses faced threatening behaviours, assault, aggression or harassment while approximately 89% of nursing staff witnessed violent actions during their work at mental health facilities (Health Commission 2005). This report highlighted the views of nursing staff and clinicians working at 265 mental health units and mental disabilities centres. Noteworthy statements of nursing staff included " *many verbal threats seem to be regularly disregarded despite its effect on the victim*" (staff member from a forensic ward/unit) and "*I personally have been physically attacked on the ward more than once and threatened with physical violence more times than I remember. You begin to*

accept this as part of the job.” (Staff member from an acute ward/unit, Health Commission 2005-P: 24).

Yet, another study from the USA revealed that fear is one of the feelings of patients themselves, not only nurses. In 2007, a survey conducted by the CDC over 37 states revealed that only 25% of patients with mental problems believe that they will receive care and sympathy for their conditions. Although this survey was conducted in the USA, it exposes an important fact about the fears and loneliness feelings of patients (CDC 2007). Many patients in this study expressed negative feelings such as fear, loneliness and isolation. Lack of support and empathy were common feelings among many patients who suffered from mental illness (CDC 2007). From an Egyptian perspective, the situation is not very different is some press release articles although statistical research regarding patients’ fear and sources of anxieties is lacking. For example Mirza (2016) gave the chance to one of the patients who was detained in a psychiatric hospital in Cairo before. The patient was describing the high level of insecurity she was going through in the hospital where she deteriorated and developed more problems due to lack of understanding or support and compassion to her condition in the hospital that depended mainly on medication administration. Another study from Saudi Arabia expressed that patients at mental health facilities could be subject to discrimination and avoidance by health care team inside the facility due to the misconception held by the staff that patients are dangerous and aggressive (Shahrour and Rehmani 2009). However, Dawood (2013) indicated that there is a link between years of nurses’ experience and their ability to manage psychiatric emergencies in an Egyptian Saudi study.

Generalisation about nurses’ perceptions regarding the stereotype about patients and feelings of fear is not appropriate. Perceptions may vary worldwide and change from place to place. Gogging’s opinion seemed to be an exception. Most literature reviewed supported the stereotype held by nurses about mental patients’ aggression (Fitzpatrick 2015, Sewilam et al 2014, Schafer et al 2011, Coker 2005). Previous description of the challenges of patients’ loneliness, lack of empathy feelings, and nurses’ fear requires attention within nursing education and health policies.

However, the situation revealed through students' perceptions in the Egyptian mental health context suggests that patients' aggression was met with cruel practice and unacceptable communication from staff that could be used as a measure to control patients. This mutual staff/patient aggression represents another source of stress for students within MHN. Students' perceptions from the current study, raised concerns regarding the need for advocacy measures and activating a health audit system for patients, particularly at governmental hospitals.

Finally, most existing studies discuss views and perceptions of stigma and stereotypes in mental illness, but do not present data to support them; this also applies in literature about whether staff are subject to aggression or about the negative stereotype and unjustified fear they hold. Literature also does not clarify the percentage frequency of these aggressive acts and whether shortage of staff, lack of resources, poor staff communication skills, inefficient staff knowledge and skills about mental illnesses are factors that aggravate the aggressive behaviour that might be avoided under different conditions.

5.1.2 Fear about patients

Some participants in the study voiced their worries regarding patients' safety at a mental health facilities and highlighted the major responsibility of MHN to protect patients. Patients' aggression towards each other and suicide were two main sources of participants' fear about patients.

Suicide is associated with shame and blame for everyone surrounding the patient. Suicide is unreported on many occasions to avoid the legal responsibility and societal blame. The researcher witnessed 2 suicidal attempts within 2 months in the same mental health hospital in Cairo and recognises that suicide is a real danger for patients and a huge responsibility for MHN. Patient suicide is a main source of anxiety and stress to nurses in mental health (Kipping 2000).

In literature that addresses the issue of suicide and attempts to alert staff working in mental health about the antecedents of patient suicide, they refer to a condition that they call malignant alienation (Watts and Morgan 1994). The alienation starts with deterioration in staff and patient relationships within

mental health facilities and with a manipulation of power and control over patients. Malignant alienation occurs when staff ignore and reject patients who do not improve and who are long stay at the facility. It is represented by loss of sympathy and support for patients (Watts and Morgan 1994). Lack of support and compassion in the relationship between staff and patients is one of the danger signs identified by Watts and Morgan (1994). However, the deterioration may often happen silently and requires attention by nurses. Consequently, it is suggested that suicidal tendency including risk assessment of self-harm and homicide should be an integral part of clinical psychiatric nursing competencies (Flaskerud 2012, Kragelund 2011, Gilje 1999). In this study, the nursing curriculum of the school does not include a psychiatric nursing curriculum, only a few related topics. Hence, it is suggested that educating nurses about the main diagnoses and the required skills might lead to decrease in anxiety. Also it is possible that the more students are taught about mental illness and the different situations they might face, stress will be decreased.

5.1.3 Power in psychiatry

The inappropriate use of power by psychiatric nurses was part of students' perception of MHN and a source of anxiety. They rejected what can be described as cruelty and limitation of patients' freedom. Power is a concept and a set of acts that are deeply rooted in psychiatric nursing, yet, it is perceived as invisible, hidden, and difficult to map and evaluate (Cutcliffe and Happell 2009). The use of power in psychiatric nursing includes aspects such as restricting patients' freedom, taking decisions on behalf of patients, and the use of certain language and terminology during communication with patients; these are all manifestations of MHN power (Cutcliffe and Happell 2009). Most of these manifestations can be captured from participants' quotes in the current study. Cutcliffe and Happell (2009) explained that to defeat the seduction of using power, nurses should first acknowledge this power and develop self-awareness of their interactions and reactions with patients since denying the problem will complicate it. However, nurses themselves who expressed that they felt powerless (Hall 2004), denied the use of power in psychiatric nursing. Yet, Hall (2004) confirmed that the issue of power within

psychiatric nursing exists, particularly with difficult patients who are perceived to be challenging nurses' authority (Hall 2004).

Participants' opinions in this study about the use of power indicate their perception of MHN as authoritative, lacking empathy and controlling patients. This view could be limited to the places they worked in or visited during training, but the overall agreement from other participants who did not have psychiatric nursing experience, supported their view.

Also, nursing educators have responsibility to address human rights, organisational behaviour and to activate an advocacy role within mental health nursing education. The echo of fear, helplessness and frustration expressed by participants deserves attention from different parties through continuous development courses for nurses at work, on site training and clinical supervision for MHN. These developments might have positive effects on current MHN practice (Henderson and Marty 2013, Henderson et al 2007, Cleary et al 2012, Mcadam and Wright 2005, Blegeberg et al 2008, Dawood 2012).

Lack of role models is another aspect that was expressed by different participants in the study. Some highlighted the issue of difficult relations between staff in the department and considered it a source of stress. Relationship in mental health has two main branches; relationship between staff and patients and relationship between staff themselves (Rungapadiachy et al 2004). Both relationships are important for the continuity of successful work. Relationship with patients requires time and effort to start the therapeutic relationship and continue it successfully (Rungapadiachy et al 2004). Participants did not present justifications for staff negative behaviour such as workload or time constraints; participants mentioned clearly that they rejected such practice. However, poor relationships with staff are a major source of stress to nursing students within mental health placement (Van Rhyn and Gontsana 2004). Thus, such stress could be one source of anxiety and discomfort for nursing students. It is also considered one of the factors that leads to poor communication and negatively affects patient care (Van Rhyn and Gontsana 2004). Although participants' subjective opinion could be based on their own work experience and the condition of the place they

worked at, yet, many supported the presence of negative issues between staff and patients and between staff and each other within mental health hospitals in Cairo. Within group 6's discussion, all participants had negative opinions about mental health nursing teams although they worked at different places for mental health services. This raises concerns regarding mental patient's dignity and human rights and how patients are treated at different psychiatric facilities. Issues of malpractice in mental health are highlighted by Rungapadiachy et al (2004) who described staff behaviour to be intimidating at times, particularly from male staff. Rungapadiachy et al (2004) suggest that nurses working in mental health should be aware of their own actions and develop their skills to be able to serve patients' interests and preserve patient dignity. From literature evidence and students' opinions that expressed their concerns about MHN practice in Cairo, it could be suggested that nursing education should pay attention to non technical skills, such as developing professional empathetic communication, team working and conflict resolution skills within mental health curricula to influence future nursing practice.

5.1.4 Concern about the issue of nurse addiction

Although participants who had previous experience of working or training in mental health expressed their worries about witnessing some nurses who became addicts, other participants who did not have the same experience had no idea about this issue. It was not clear from participants if this was a common or accidental issue among nurses, but it was evident that it is one of their fears. Addiction among nurses is recognised and considered as a problem that threatens public safety (Monroe and Kenaga 2010, Monroe 2009, Clark and Farnsworth 2006, Heise 2003, Shaw et al 2003, Griffith 1999). Moreover, Monroe and Kenaga (2010) argued that an estimate of up to 20% of nurses struggle with substance abuse. Monroe (2009) explored initiatives in USA that urge schools of nursing to consider substance abuse as an illness that needs support and recovery. However, Monroe and Kenaga (2010), Monroe (2009) and Griffith (1999) warned that the zero tolerance and dismissal policies could lead to diminished reporting of the problem by nurses or colleagues to avoid disciplinary actions. They call for more supportive treatment allowing the chance for rehabilitation. Exploring nurses' addiction

problem revealed that schools of nursing are committed to adopting humanistic confidential supportive policies that will encourage students to express the problem and protect the safety of society (Monroe 2009).

In relation to this study, results suggest that addiction is one of the fears that could be associated with psychiatric nurses. Some participants believed that long working hours and workload, together with the availability of drugs are reasons to put MHN at risk. However, students' perceptions regarding addiction could lack insight. Most branches of nursing struggle with workload due to shortage of staff and addictive drugs are available to many nurses, for example anaesthesia nurses and Intensive care unit nurses. The problem is not limited to psychiatric nurses. Students' opinions could be related to the only examples they knew of being previous psychiatric nurses. However, participants' fear is justified because of the stigma of addiction, where it is perceived to be a criminal act and "a moral failure" and blocks initiatives for recovery (Heise 2003). In Egypt, schools of nursing and hospitals adopt dismissal policies for nurses who are suspected of struggling with drug abuse. This could lead to more covering and hiding of the problem until it reaches a late stage that threatens personal safety and jeopardises community wellbeing.

5.1.5 A stigmatizing career?

Some articles suggest that the issue of stigma is associated with working in the field of mental health. Halter (2002) describes real situations told by nurses working in mental health. In one such situation "a nurse was told by her colleague that she looks too normal for a psychiatric nurse". Also Halter (2002) presented a situation from a conference in Ohio where attendees were asked whether psychiatric nurses are stigmatized and most replied "...of course they are". Moreover, Halter suggested that nursing students themselves stigmatize MHN, just as the public do. From an Egyptian perspective, Sidhom et al (2014) highlighted that the issue of social stigma associated with mental illness in Egypt also extends to psychiatrists. However, Sidhom et al's research did not explore Egyptian nurses' perception of mental illness and how this can affect nursing students' view and career

choice in this field of practice. The current study was seeking to add understanding of student nurses' perception and whether mental health stigma was an issue for them.

Participants acknowledged that Egyptian society, including nurses' own families, do stigmatise psychiatric nursing and consider it to be a dangerous or intolerable career. Yet, it was an unexpected and new finding from participants when they said that society's view was the last thing they thought about. Participants did not show support for the societal view of mental patients and pointed to society's dangerous beliefs, such as urging patients not to seek medical help. Such beliefs, that keep patients away from treatment and result in deteriorating conditions, need to end. Participants expressed that Egyptian society already stigmatizes a nursing career and does not respect it, so caring about society's perception of MHN was not significant for them. Although social stigma seemed not to be one of students' concerns, study results can suggest that public stigma leads to social distance; discrimination against patients and putting pressure on them needs to end.

Countries such as Australia and the United Kingdom recognised the problem of social stigma associated with mental illness early and started to raise awareness and professional understanding of mental health (Halter 2002). Moreover, The Centre of Disease Prevention and Control (CDC 2013) called for more public awareness regarding mental health stigma in the USA. It asserted that stigma associated with mental illness needs to be condemned since it is a cause of unneeded suffering for patients (CDC 2013). The same perspective came from Coker (2005) who conducted her research about mental illness stigma in Egypt. She suggested family and friends' support as a means to defeat stigma (Coker 2005). Sewilam et al's (2015) suggestions to combat social stigma included education about mental illness specially for young people, using the media, and engaging religious leaders as a role models for the society to follow. Such initiatives are not activated yet in Egypt.

5.1.6 ECT as a source of stigma in relation to a Mental Health Nursing career

ECT is considered one of the treatments that is recognised as effective with many conditions that might not respond to pharmacological therapy (Smith and Gallagher 2011). Yet, it is still controversial and presented in many Arabic and international media productions as a kind of torture and punishment to patients (Payne and Prudic 2009). Within students' image of MHN most opinions linked ECT and stigma. However, participants who attended psychiatric placement did not have the same opinion and stressors related to this procedure. MHNs have many roles and responsibilities in clinical practice, yet, it was observed that participants picked ECT to focus on. ECT is seen as a punitive, scary, painful procedure since it is regarded as "electricity".

Students' opinions not only reflect their lack of knowledge about ECT, its effect and how it works, but they also mirror the media presentation of the procedure. Students expressed their uncertainty about the nature of ECT as a treatment. Some of them admitted that they lacked information about it, hence they were unable to judge if it is good or bad. However, most participants expressed it is scary. Consequently, it can be understood that part of participants' perception of MHN was that they will participate in a psychologically frightening job. Literature suggests that educating nurses about different procedures such as ECT and explaining its effect would help to defeat any negative beliefs about the procedure (Balhara et al 2012, Gass 1998).

Not all literature is positive about ECT and some conveys similar opinions to the current study results. For example, Dawson (1997) who worked as a psychiatric nurse presented a very negative perception about ECT. Although Dawson's paper represented a humanistic nursing reflection within psychiatric nursing work, it questioned the effectiveness of ECT as a cure, asking if the aim is to cure patients or just to make them manageable. Dawson (2012) called ECT a "the electrical assault" and expressed her rejection and opposition to such treatment. ECT is also associated to some extent with stigma that extends to MHN (Kavanagh and McLoughlin 2009). Hence, it can

be concluded that education about ECT might make a difference in supporting a more positive attitude by nurses towards ECT; however, it may still be a controversial procedure.

5.1.7 Mental health nursing education: its potential to combat stereotype and stigma

The majority of participants in this study rejected the idea of working as a MHN and expressed their fear of unexpected patient reactions, aggression or assault. Few participants emphasized that they would like to work in MHN regardless of their fears, aiming to help patients and advocate for them. Both groups of participants (those rejecting and those accepting work as MHN) called for more representation of mental health topics in their curriculum, for supervised training at psychiatric facilities and adequate clinical placement in mental health. Even participants who went to mental health departments during the summer training lacked any kind of supervision from the school. Also faculty students from the pilot group who had a whole semester about mental health, expressed they lacked knowledge about many details within psychiatric nursing and were unable to help patients in many situations. Most participants emphasised the need for psychiatric nursing education and clinical training to enable them work in this field if they decided to do so. They acknowledged education as an element to challenge negative stereotypes about mental illness. Students expressed that they needed role models in order to recognise clearly what would be the role of mental health nurse. Students' perceptions left unanswered questions such as, would education make the anticipated change in nurses' perception to MHN, is this opinion congruent with literature evidence and are there other influences that would interfere with nursing education's effect on students.

Many studies identified the effect of mental health nursing education and of clinical experience in psychiatry in changing nurses' perception to a more positive view and supporting confidence to work in this field (Dawood 2012, Schafer et al 2011, Higgins and McCarthy 2005, Rhyn and Gontsana 1992). However, clinical training could be useful only if it is well planned (Moagi 2013). The value of clinical psychiatric training for nurses is acknowledged as

enhancing a positive attitude towards patients as asserted by Moagi et al (2013) who highlight the significant role of the clinical educator. Moagi et al 2013 suggest that successful clinical training needs to plan a structured learning experience for students, to facilitate communication with staff and to provide guidance and support for students to maximize their learning opportunity. Hence, it can be suggested that participants' perceptions in the current study are congruent with literature that puts importance on clinical psychiatric training for nurses. This training needs to be well designed and planned to achieve its aim.

Dawood (2012) who conducted her research with over 114 nursing students at King Saud University in Saudi Arabia, suggests that clinical experience in psychiatry enabled students to adopt more positive perceptions about psychiatric nursing. The researcher believes that this view is difficult to generalise, despite the strong effect of clinical placement on students' perception of psychiatry in Dawood's (2012) study. However, the situation is different in Egypt where a huge economics related gap is happening and is mirrored in the health care services. This gap is also reflected in private (expensive) and governmental (cheap or free of charge) hospitals. Students in the current study pointed many times to socio-economic variations and considered it part of their perception of MHN. Through describing their perceptions about MHN, students referred to the differences between private and governmental hospitals. They believed that private ones will be much better regarding training, work opportunities, facilities and that patient rights will be more protected there, than at government hospitals.

During a previous experience of supervising university students, I witnessed the positive change in students' perception and attitude towards psychiatric patients after the clinical placement that took place in one of the private hospitals in Cairo. Particularly this training left a very positive impression with students who believed they would choose MHN as an elective module in future. Yet, the researcher experienced a huge challenge in a previous semester that took place in one of the governmental hospitals where shortage of staff, patient aggression, lacking facilities and locking patients inside were

very common. During this training, students were demotivated, anxious and expressed that training was psychologically exhausting to them.

The two scenes were completely opposite to each other, where a private hospital has all the facilities, open gardens and special assistants to patients as required and the government hospital is locking patients inside without any source of recreation and shortage of staff. Hence, perception about MHN in Egypt is affected by the chance of clinical training and the place of clinical training.

However, there is the question of who can afford treatment cost at private psychiatric hospitals that require thousands of pounds on admission and very expensive treatment in a country like Egypt where more than 40% of population are under poverty line (earn less than 10 \$/week). It can be concluded that economic conditions affect not only patients and their families but also the preferences of nurses' working places and their career choice. Earlier this year, The World Bank addressed that issue of social justice within health care in Egypt in a report that was released last January (World Bank 2015).

Finally it is suggested that nursing education is one of the keys to changing any negative practice and stereotyping of patients (Gogging 2010, Happel and Gough 2007).

5.2 Limitations of the study

Although participants of the study represent school of nursing students' opinions, yet generalisation of results is not applicable. The sample of the study was convenient sample and therefore, results generated could be subject to change if the place of the study changed. Other nursing schools may have a different curriculum and training plan, and students could have different experiences and perceptions. Particularly the schools that are located inside mental health hospitals, such as Abbasia school of nursing and another Psychiatric hospital nursing school, at Helwan area, who have a great

interest in MHN training and most of their graduates work at mental health facilities. Students' opinion at the MTI was not different, still, the situation regarding faculties of nursing and students' perception of MHN there is not yet clear and needs to be explored if further improvement to quality of education will take place. Moreover, the research conducted in Cairo at the heart of Egypt, could bring different results if conducted at different governorates in upper Egypt, where different culture issues might influence participants' opinions. Moreover, some governorates in Egypt do not have a psychiatric hospital and this could lead the discussions there towards employability issues and financial constraints on nurses.

In this study, variances in students' experience existed since some students did not have any experience of working or training in mental health. Their opinions were built on observations, friends' experiences and what they saw in the media. If all participants had experience in MHN, either through clinical training or work experience, some opinions could have been different.

Another issue regarding participants was related to the focus group methodology. Focus group is an ideal method of qualitative data collection when it comes to group interaction and collective constructions of meanings (Willing 2013). Yet, issues such as group polarization during focus group may appear. Group polarisation was one of the weaknesses that had to be managed by the researcher during group interview. The option of individualised interview with students to overcome this problem was not taken, as it could cause real threat to students and hinder interaction with the researcher. Therefore, group interview was an ideal option to generate knowledge.

Regarding the size of focus groups, the researcher decided to keep all groups to less than 5, in order to control discussion when there were many interruptions caused by participants who were motivated to defend their opinion. The total number of participants during the study was small, 32 only, while each year includes more than 120 student. The researcher decided to stop the interviews at the point when the results became similar and no new

knowledge was generated. However, widening participation to include other students from other organizations could bring richer results and additional new knowledge. Also, participants had different experiences that at times influenced the discussions and their perceptions of MHN. Participants were chosen to be similar as far as possible, from the same year and similar in age. Some participants had clinical training at mental health and some did not have this opportunity. Also some participants worked privately at mental health and others did not have this experience.

Kevern and Webb (2001) highlighted one of the focus group limitations in relation to student/teacher relationship and raised the issue of reflexivity and sensitivity of the researcher to plan a nonthreatening atmosphere. This limitation was minimised as much as possible, because the students did not know the researcher as a teacher and the researcher was not and would not be involved in any teaching activities with them while they waited for graduation. The researcher acknowledged her relationship with the school for volunteer work and students observed the relationship between researcher and schoolteachers during the preparatory stage for the research and the initial presentation of the study. The researcher tried to overcome any anxiety that might exist through encouraging students to express their opinions and assure confidentiality and anonymity during participation in the study. The researcher also emphasized several times that students' own perceptions and opinions would not be shared with teachers.

A final issue was the minimum experience of the researcher in conducting qualitative studies and facilitating focus groups. This issue sometimes caused unintended pitfalls such as occasionally using closed questions during the interview and showing both positive and negative reactions to participants. This happened infrequently but could have been avoided if the researcher had previous experience in conducting qualitative research.

5.3 Recommendations from the study

Taking into consideration the limitations of the study, the following tentative recommendations are made:

- The structure of the mental health nursing curriculum within schools of nursing requires attention and development.
- Supervised clinical training, and role modelling and mentoring in mental health, will help students to overcome part of their anxiety regarding communication with patients and to recognise the role of the mental health nurse.
- Attention should be given to the gap between theory and practice in mental health.
- The concepts of stigma, fear, power and stereotype should be explored.
- Conducting field visits to mental health facilities would help students to recognise the different levels of care in the Egyptian health system. This also would help students to recognise variations in care that are related to the variable socioeconomic state of patients.

5.4 Conclusions and future work

This research is the first study to investigate students' perceptions regarding psychiatric nursing within the school of nursing at Cairo University. It explored the research question through in-depth analysis of participants' views and opinions in a nonthreatening atmosphere. The critical inquiry within this qualitative research presented rich data on students' fears, challenges and motivations that surround working in psychiatric nursing. Stigma and fear were two integral parts of perceptions of MHN, yet, a few students were not concerned about the stigma and were willing to work in this field.

Fear and avoidance in MHN is not limited to Egypt and one can assume that it is not the effect of culture alone that keeps nurses away from MHN; fear of patients, potential risks and social stigma are also influencing nurses' choice. It appeared from the study results that nurses are not separate from, but are part of the social reality within the Egyptian society and that Egypt has a long way to go, to enhance MHN education. Finally, further research will be required to uncover the hidden part of the picture, concerning the experiences

and perceptions of patients themselves and their opinions of MHN and of the health service provided in general.

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Appendix 1

Final Interview Question Guide

1- Introduction:

- Introduction to the research and the researcher background
- Introducing aims and objectives of the study
- Explain confidentiality issues and ethical considerations
- Explain the rationale for recording the discussion
- Obtain the consent for participation
- Check for any questions and the need for further explanation

2- Background of mental health nursing training:

Aim: to Encourage participants to speak about their previous experience on mental health training

- Working with mental patients (How can you describe the experience)
- Sources of support during **training** (explain how and what)
- Challenges and difficulties
- Mental health nursing as a **career choice** (considering MHN compared to other nursing specialties as a career choice)

3- Perception about mental health nursing:

Aim: to explore different perceptions about mental health nursing and which factors affect developing this perception

- How participants would describe working within the field of MHN?
- What are the factors that attract participants to work as MHN?
- What would be the factors that discourage participants from working as MHN?
- From your own opinion, how can you hierarchy the next nursing specialty from the best to the worst (ICU nursing, neonatal care nursing, mental health nursing, orthopaedic nursing and gynaecological nursing)?

4- The Egyptian society and mental health nursing:

Aim: to explore whether the society and culture has an effect on participants' perceptions of MHN

- How can you see MHN from the eyes of people outside the health field?
- How others' opinion affect your perception to MHN?
- In which terms MHN is different from other branches of nursing?
- Can you describe your opinion regarding how the society evaluates MHN?
- What would be the factors that affect society's perception to MHN?

5- Role identification and professional practice:

Aim: the main concern during the pilot interview at the MTI was that students were not sure what would be their role and how they might advocate for patients. Therefore, this point was considered to be part of the interview guide, since lack of knowledge regarding the role of MHN may affect perception for the career

- Can you describe the role of mental health nurse
- What are the sources of fears and stress-if any- within this career?
- Can you describe your interaction with patients who are mentally ill and they don't pray,.. have multiple relationships....

6- In conclusion

- Conclusions of main points raised during the discussions
- Thank participants for sharing their opinions
- Assert confidentiality issues and anonymity during data analysis
- Ending the recording

Appendix 2

Ground rule for focus group

- Participation in the study is voluntary
- There are no right or wrong answers: Each member of the group should respect others opinion and participate in the discussion without correcting others
- Team members have the right to disagree and criticize, and express their opinion without attacking others' opinion or correcting others.
- Team members have the right to question and ask for clarifications if needed
- Respecting confidentiality: what is said in the discussion stays in the room and this apply to participants and researcher as will.
- No reward or punishment: participants opinions' are respected and students will not be rewarded or punished for their opinion
- No participant names will be called during the recorded discussion
- The maximum time for each focus group is 60 minutes
- Only participants of the focus group and the researcher will attend
- The focus group is taking place at one of the classes of nursing school
- Separate conversation is not allowed, you can share your ideas within the discussion
- Phones are turned off during the discussion

Appendix 3- Information Sheet

My name is Amira El Baqary and I'm doing research on perceptions of nurses in relation to mental health nursing. This research is part of my Doctorate study at Queen Margaret University.

The title of the research is: Exploring Nursing Students' Perceptions of Mental Health Nursing in Egypt

It is expected that results of this research will be beneficial in understanding nursing students' learning experience and attitude towards mental patients. Consequently, it should add some recommendations in relation to enhancing psychiatric nursing and promoting patient care strategies. The aim of this research is to explore nursing students learning experience in psychiatric clinical practice and provide recommendations for enhancing teaching strategies of psychiatric nursing.

The study is totally funded by the researcher

I am looking for fourth year nursing student volunteers to participate in the project. There are no criteria (e.g. gender, age, or health) for being included or excluded – everyone is welcome to take part.

If you agree to participate in the study, you will be asked to join one focus group that will take place in the university to discuss the research topic. The whole meeting should take no longer than one hour and you will be free to withdraw from the study at any stage and you would not have to give a reason.

All data will be anonymised as much as possible, and it will not be possible for you to be identified in any reporting of the data gathered.

The results may be published in a journal or presented at a conference.

You can contact the researcher for any further enquiries or information and contact details of the researcher will be found below.


If you have read and understood this information sheet, any questions you had have been answered, and you would like to be a participant in the study, please now see the consent form.

Contact details of the researcher

Name of researcher: Amira El Baqary

Mobile Number: 002 01065779646

Email : 10009457@gmu.ac.uk , Amira.abdou@ymail.com


Queen Margaret University
EDINBURGH

Perception of nursing students towards mental health nursing

Introduction: the researcher is doing Doctorate of Health and Social Sciences (Nursing) at Queen Margaret University, Edinburgh. The focus of study is community and mental health, Nursing education development, Elderly care.

Research aim: The aim of this research is exploring perception about mental health nursing from student nurses perspective.

Research strategy: Qualitative research

Research Method: **Focus group** interview with students.

Significance of the study: there is an observed shortage in psychiatric nursing in Egypt. Also working in the field of psychiatric nursing could be accompanied with worries and some negative feelings and stigma. This research aims to explore students' nurses' perception regarding working in the field of mental health nursing.

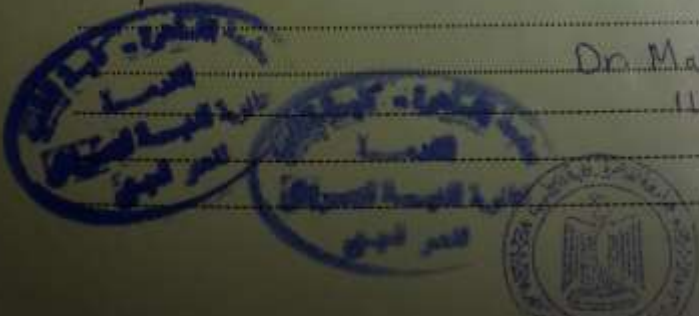
Ethical consideration: the researcher is committed to keep the privacy and confidentiality of data and arrange with the faculty of nursing for any required measures required by the faculty.

The researcher: Amira A El Baqary


Director of study: Dr Lindesay Irvine

Faculty comment:
..... She can work with great
..... pleasure. The research is of importance.

Dr Maha Ghobash
14/5/2015



Appendix 5


Queen Margaret University
EDINBURGH

Perception of nursing students towards mental health nursing

Introduction: the researcher is doing Doctorate of Health and Social Sciences (Nursing) at Queen Margaret University, Edinburgh. The focus of study is community and mental health, Nursing education development, Elderly care.

Research aim: The aim of this research is exploring perception about mental health nursing from student nurses perspective.

Research strategy: Qualitative research

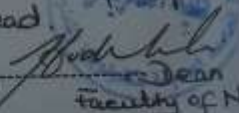
Research Method: Focus group interview with students facilitated by the researcher

Significance of the study: there is an observed shortage in psychiatric nursing in Egypt. Also working in the field of psychiatric nursing could be accompanied with worries and some negative feelings and stigma. This research aims to explore students' nurses' perception regarding working in the field of mental health nursing.

Ethical consideration: the researcher is committed to keep the privacy and confidentiality of data and arrange with the faculty of nursing for any required measures required by the faculty.

The researcher: Amira A El Baqary

Director of study: Dr Lindesay Irvine

*Approved according to
opinion of department
Head.*

Dean
Faculty of Nursing
MTT

Faculty comment:
The research title is of importance as it has application in the field of psychiatric Mental Health Nursing. Its results could be informative, and could inspire us as educators in adding new strategies concerning the transferable skills to let our learner appreciate the value of the speciality.
Neinab Douk

Appendix 6 – Research consent

Research Title: Exploring Nursing Students' Perception on Mental Health Nursing in Egypt

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.
I understand that I am under no obligation to take part in this study.
I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: _____

Signature of participant: _____

Signature of researcher: _____

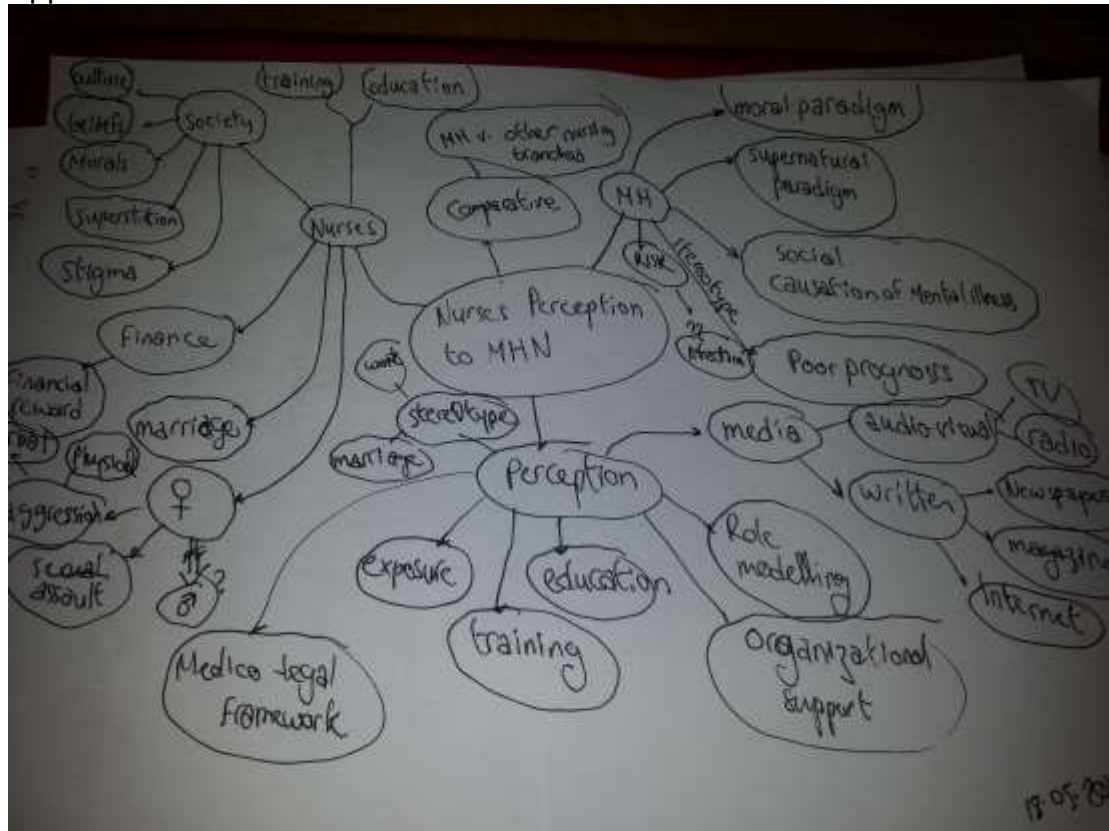
Date: _____

Contact details of the researcher

Name of researcher: Amira El Baqary

E-mail/ telephone: : 10009457@gmu.ac.uk

Appendix 7



Appendix 8

Data analysis draft (1)

8 groups and 32 participants

253 sentences coded

52 codes for the data

Themes: stigma, career choice, different challenges to working as MHN

Quotes	Code	Theme
Group 3 – 4 participants		
The psychological state of the patient is important to be understood (G3-P1)	Humanistic role of nursing	
MHN is important and unique as well rather than medical and surgical specialties, and it is different in terms of communication with patients (G3-P2,3)	Difference between medical specialties and psychiatric nursing	
The problem is the society who stigmatize it and many become afraid of patients when they know they are psychiatric patients (G3-P2)	Stigma: fear of patients	
I think the perception to mental health nursing is negative “the doctor of the insane”, but if people are psychologically distressed they will not be able to do anything (G3-P4)	Stigma of mental health nursing, disabling nature of mental illness	
I believe the psychiatrist is very important (G3- P4)	The importance of psychiatrists	
if there are no psychiatrists who will treat all the mentally ill patients (G3 – P3)	The importance of psychiatrists	
the role of mental health nurse we recognized in the third year (G3 –P1)	Lack of recognition of mental health nursing	
we didn’t have any MHN clinical training (G3 – All)	Lack of clinical training	
I prefer yes to work as MHN (G3- P1)	Choosing MHN as a career choice	
the work will be easier than other branches (G3 – P1)	Expectations about low workload	
yes I believe they need someone to understand them (G3 – P1)	The humanistic role of nursing	
Communication with patient will be difficult (G3 – P4)	Communication barrier with patients	

how I will communicate with depressed , or manic patients(G3 – P4)	Communication barrier with patients	
Patients might do anything while they are not responsible for their actions(G3 – P4)	Stigma: fear of patients	

I will think twice before choosing to work as a MHN(G3 – P4)	Stigma: fear of patients	
Just need to think more about working as a MHN (G3 – P4)	Hesitancy prior to choosing MHN	
If we have enough clinical training , we will work as MHN (G3 – P4)	Need for clinical training	
Only lacking clinical training is my problem (G3 – P4)	Need for clinical training	
if we have psychiatric clinical training, maybe we will have more confidence to work as MHN (G3, P1, P2)	Need for clinical training	
I don't like this field and not willing to work as MHN (G3,P3)	Hesitancy prior to choosing MHN Rejection of MHN	
Maybe if I worked with them, I would like the field (G3,P3)	Hesitancy prior to choosing MHN	
the problem is....if I don't know how to communicate with the patient I will not be able to work. (G3- P1)	Need for clinical training; communication barrier with patients with mental illness	
Don't feel there is a stigmawe are nurses...should work with every patients (G3-P2)	The professional role of nurses	
The patients needs someone to listen to him....someone to understand his suffer, who can make him calm....just be with them (G3-P1)	The professional role of nursing	
I believe patients needs us (G3-P3)	The professional role of nursing	
I don't care about the stigma, (G3, P2)	Unconcerned about stigma	Positive
it is about education (G3-Q1)	Need for clinical training	
MHN is an important field for any patient (G3-P4)	Importance of MHN	
Most of the topics we studied theoretical content ,,not sure about clinical (G3-P4)	Need for clinical training	
I wish to see the patients and communicate with them (G3-P2)	Motivated to work at MHN	
We need to learn how to communicate with patients, what would be our role in the clinical psychiatry (G3-P1)	Need for clinical training, the need to learn communication	
We thought to go to the hospital once , but we need a teacher with us, can't enter the hospital alone (G3-P1,P2)	Need for clinical training, need for supervision	
if we didn't work as psychiatric nurses, we will meet mentally ill patients in our lives or in general	Importance of MHN	

hospital and outpatient clinics,therefore, it is important to learn psychiatric nursing (G3-P1)		
to be able to communicate with different patients at different situations (G3-P4)	Communication with patients	
patients might not trust the care providers easily, people might get pored because patients do not respond to treatment or lack confidence in the staff (G3-P2)	Lacking trust of mental health nurses	
I think nurses should control their facial expressions and avoid any criticism to patients (G3-P4)	nonverbal communication communication barrier	
Mental patients need help (G3-P1,2)	The professional role of MHN	
Some situations could be unexpected with psychiatric patients (G3-P3)	Stigma: fear of patients	
People usually either afraid of them or trying to help them but don't know how...I mean ...particularly schizophrenic patients are not welcomed among people (G3-P1)	Stigma: fear of patients	
The society is not really sympathetic with mental patients,don't mean everyone...but the majority of people don't like mental patients to be around or near from them... (G3-P2,3)	Rejection of mental patients	
Majority of the society have a negative image about MHN.... <i>"you deal with the insane,,,, you are like them"</i> (G3-P4)	Stigma of working with mental patients/ rejection of mental patients	
Yes...I agree...many people stigmatize nurses when they work in the field of psychiatry (G3-P3)	Stigma of working with mental patients	
for example if you said something that is not understoodor even controversial ...people say "are you	Stigma of working with mental patients	

from Abbasiya” ...so Abbasiya is the old asylum of the psychiatric patients... (G3-P2)		
I’m afraid about suicidal patients.... suppose that he harmed himself while I’m busy with another patient...I will not forgive myself (G3-P1)	The professional role of MHN/Lack of confidence to work as MHN	
Yes suicide is really a danger and a responsibility for MHN, nurses carry all the mistakes at the end (G3-P2)	Lack of confidence and fear of responsibility as MHN	
Also aggressive violence situations, patients might harm each other!! (G3-P3)	Stigma: fear of mental patients violence potential behavior/ Fear of responsibility as MHN	
Many situations can happen, we are as nurses always overloaded, but my fear is about the patient ,, not about the responsibility , he is a human (G3-P4)	The humanistic role of nursing	
Patients can do anything violent and considered irresponsible!! This will make me uncomfortable (G3-P3)	Stigma: fear of mental patients violence potential behavior	
I believe my own safety will be in danger (G3-P1,2)	Stigma: fear of mental patients violence potential behavior	
Group 2-----4 participants		
I think MHN is a difficult specialty.... there are no clear signs.... the patient might not be able to express his suffer, signs and symptoms are hidden, (G2-P1)	Hesitancy prior to choosing MHN	
I believe my role will be mainly observation of patients’ behaviors and interactions (G2-P1)	The professional role of MHN	
Working at MHN is very positive experience (G2-P2)	Motivated to work at MHN	
MHN is important as well	Motivated to work at MHN	

(G2-P3)		
may be....it is difficult, not too many would like to go for MHN (G2-P4)	Rejection of MHN as a career choice	
I believe many nurses think it is not an important field....we are not used to hear the title "mental health nurse" ,,,, (G2-P4)	The hierarchy of nursing specialty preferences	
Many people don't know what is the work of Mental health nurse (G2-P3)	Lack of knowledge about the role of MHN	
Not sure if the field of MH require nurses or nurse aids ?? and people sometimes say "MHN...what does this mean...what is role of MHN? I don't know...." (G2-P2)	Lack of knowledge about the role of MHN	
Me too...not sure what is the role of mental health nurse (G2-P1)	Lack of knowledge about the role of MHN	
the important specialties in nursing are operation nurse, neonatal nurses and ICU....other specialties are seen as lower branches...or...like a second class nursing (G2-P3)	The hierarchy of nursing specialty preferences	
I thinkmost of us ...prefer to stay away from anything related to psychiatry (G2-P4)	Stigma of working as MHN	
In my opinion .. nurses seek chances of employability as I explained the common and important branches in nursing are operation nurse, ICU and neonatal...those specialties have the highest chances of work (G2-P3)	Low chances of employability in MHN	
yes, I agree...some nursing specialties have high more employability rates than others (G2-P2)	Low chances of employability in MHN	
that's true about the chances of	Low chances of employability in MHN	

employability , specially that people know psychiatric disorders take long time and low recovery chances (G2-P1)		
and progress of mental patient is slow, therefore not too many nurses don't prefer this field to work at ...(G2-P4)	Lack of motivation to work at MHN	
and nurses may be...don't know what they should do to patients.....the role of MHN is not very clear to many of us... (G2-P2)	Lack of knowledge about MHN role	
I believe chances to find a job for MHN are rare (G2-P3)	Low chances of employability in MHN	
it is difficult to know what should we do with depressed patient for example... (G2-P2)	Lack of knowledge about MHN role	
yes, that's right I'm not sure what are the responsibilities of MHN (G2-P1)	Lack of knowledge about MHN role	
for example when we go to apply to work at any hospital , most hospitals ask for OR, and ICU nurses, (G2-P3)	Low chances of employability in MHN	
maybe ...I don't know where to apply to work as MHN...where are the psychiatric hospitals located.... (G2-P3)	Low chances of employability in MHN	
and not sure if psychiatric hospitals will accept us to work there.... (G2-P1)	Hesitancy prior to choosing MHN	
I believe MHN are not as important as other nursing specialty.... I mean...MHN main role is to give medications only... without any other duty towards the patient....without enough care to the patient....this is what I see at hospitals... (G2-P4)	The hierarchy of nursing specialty preferences	

when I went to mental health department at Qasr el Einy hospital ... I saw negative nursing practice such as nurses shout at patients or ignore them, or just lock them inside , don't want to be like this (G2-P2)	The negative attitude of MHN	
.... nurses don't even consider patients psychological state or support them (G2-P1)	The negative attitude of MHN	
.. even if the patient refused his medication, nurses don't care about him, or even to notify doctors about the deterioration, usually this doesn't happen.. (G2-P4)	The negative attitude of MHN	
also nurses lack the observation skills,,, such as the signs that exceeds suicide...patient doesn't suicide suddenly.....the nurse should observe ...(G2-P1)	The negative attitude of MHN	
maybe we don't have MHN education, ...as a specialty (G2-P3)	The need for enhancing MHN education	
nurses are not trained enough, where is the role of ministry of health, why there are no programs to educate nurses about mental health, (G2-P4)	Lack of clinical training as MHN	
the point is education...there is lack of specialized education in the field of MHN (G2-P2,3)	The need for enhancing MHN education	
we don't know how to communicate with patients....we didn't have clinical training on psychiatry (G2-P2)	Lack of clinical training as MHN	
3 of us went to psychiatric department once, but they felt lost...didn't know what we should do (G2-P4)	Education and clinical supervision	
yes...theory is not enough, we need	Need for clinical training as MHN	

someone to show us what to do,,what to observe.... (G2-P1)		
I agree ... even when some of us went to psychiatric department...we were left there without any guidance or supervision Even the medication will be prepared and administered by the department nurse (G2-P3)	Need for clinical supervision	
regarding MHN....we need a role model...someone to shadow and follow then we might decide to join this field or not....(G2-P2)	Need for clinical supervision	
We wish we had an instructor to observe and guide us in MHN (G2-P3)	Need for clinical supervision	37 sentence
Group 1- three participants		
best specialty is critical care and ICU, worst is mental health (G1-P1)	Rejection of MHN as a career choice	
best is ICU and OR nursing but worst is Mental health and community health nursing (G1-P2)	Rejection of MHN as a career choice	
not sure about the best but worst is mental health nursing (G1-P3)	Rejection of MHN as a career choice	
I don't like to work as a MHN but if I thought about it my family will prevent me (G1-P1)	Hesitancy to work as MHN, family rejection due to stigma	
I will not work as a MHN, I can't (G1-P2)	Rejection of MHN as a career choice	
yes I mean that it is the last specialty to think about (G1-P3)	Rejection of MHN as a career choice	
in my family they would say that I will end up crazy and insane like the patients , the issue is related to the culture which refuse I think this whole issue (G1-P1)	Stigma of working as MHN	
I have the same opinion, the community don't appreciate working at MNH (G1-P2)	Stigma of working as MHN	
if we ignored the bad picture of the MH in the media and the cultural stigma how can I overcome the issue of ECT, restraints, aggressive	Role of media in degrading MHN Stigma of ECT and aggressive behavior of MHN	

situations that might happen, I believe the stigma of working as a nurse is enough already (G1-P3)		
.... the society consider nursing is not a respectful career (G1-P3)	Stigma of working as a nurse	
The ECT is shown in the media as a punishment for patients and I'm really worried from this practice, I still don't have enough information about ECT although I finished the year, so can't decide if it is something accepted and consider a kind of treatment or not, I have no idea about its advantages and disadvantages (G1-P3)	Stigma of ECT Lack of knowledge about ECT The role of media of stigmatizing ECT	
... I don't know enough information about ECT, but the media is scary (G1-P1)	The role of media of stigmatizing ECT	
I also agree about the media is frightening regarding ECT (G1-P2)	The role of media of stigmatizing ECT	
I liked talking to the patients when there is a chance , I like when they trust me and start to speak with me, but it wasn't clear for me what is the MHN role, I just don't know what should I do expect giving medications (G1-P1)	Lack of knowledge regarding role of MHN	
...most of the staff working in the place were nurse aids , only one nurse was responsible for medication administration, the communication between health team was aggressive and loud, I liked staying with the patients but from another point, I didn't like to be part of this aggressive team, communication was really bad. (G1-P2)	Lack of MHN role model	
the clinical training confirmed to me that MHN is not suitable for me, there is no one who will listen to you when you speak for patients, you just apply doctors orders, MHN opinions are not appreciated, I wish there was a role model that I can follow, I believe abroad nurses do patient assessment and can diagnose as well and are appreciated, I wish we become like this one day (G1-P3)	Rejection of MHN as a career choice Lack of advocacy role of MHN	
who will listen to me when I speak on behalf of the patient, no one will appreciate what I say, I feel worthless in this field of MHN (G1-P3)	Lack of advocacy role of MHN	
I'm not quit aware of my advocacy role, not sure how can I activate it and who will listen (G1-P1)	Lack of advocacy role of MHN	
not sure about this, I'm worried most of the time from any aggressive situation that can happen from patients , sometimes patients are	Stigma: mental patients potentially violence	

dangerous (G1-P2)		
in our culture people are not open to talk about mental illness, while it's more easy in the USA for example, here we don't seek help until our back is to the wall, I mean we seek medical help when the person can't live with his illness and when he deteriorates to the level that interrupts his life (G1-P1)	Stigma of mental illness in the Egyptian community Stigma of seeking psychiatric medical help	
yes, it is not easy to talk about mental health, even depression sometimes considered a stigma, we tend to hid the problem not solving it, so the nurse will see the patient when he deteriorate not at the early stages two:(G1-P3)	Stigma of mental illness in the Egyptian community	
more clinical placement and to take part at different paces. (G1-P1)	Need for more clinical training as MHN	
yes the clinical placement to be longer and I believe we need to see some private hospitals to check if the conditions are same and care strategies are similar (G1-P3)	Need for more clinical training as MHN	24 sentence
Group 4- three participants		
It's a male job, don't think we should work at MH as females, I might be in danger and threatening situations, it's my opinion...(G4-P1)	Gender issue: MHN is a male job Stigma: mental patients potentially violence	
The patients at MH might not be responsible for their actions, I mean...they might be aware of what they are doing, ..and who will defend me inform of this danger ,,, in general hospitals for example you can find people are not responsible for their actions due to coma and other health issues but MH is different they might be dangerous ...(G4-P1)	Stigma: mental patients potentially violence	
I didn't go but one of our colleagues was attacked by a psychiatric patient during her work at the orthopedic department, she was verbally insulted and she felt so embarrassed and was not able to work with this patient, so what will happen if I went to work at a psychiatric hospital...	Stigma: mental patients potentially violence	

(G4-P1)		
.....mental patients are not dangerous all the time, I think they need help (G4-P2)	Role of Mental health nurse	
.... just don't feel comfortable to the idea of working with them, not all the patients are aggressive I know this (G4-P3)	Stigma: mental patients potentially violence	
patients' potential aggression is probably one of the factors that keeps me away from this specialty (G4-P2)	Stigma: mental patients potentially violence	
I can work at MHN, but I will be worried from assault.. (G4-P3)	Stigma: mental patients potentially violence	
We should excuse patients .. for example if we are verbally attacked by a patient in a general hospital , we keep silent and overcome the situation because he is a patient, so what if this patient is a psychiatric patient....(G4-P2)	The professional role of Nurses	
I don't agree.. you will not keep silent when a patient hit you or tried to kill you...(G4-P1)	Stigma: Mental patients potential aggression	
if I only can guarantee Abbasyia Psychiatric hospital is a safe place and I will work in a safe environment , I will go to work there (G4-P3)	Stigma: mental patients potentially violence	
the problem is related to risk factors and lack of safety in the hospital,,,but the society's view and stigma to MHN is not important to me ...(G4-P1)	Stigma: mental patients potentially violence	
the society already stigmatize nursing as a career in itself, (G4-P2)	Stigma of nursing career	
**and if you work for example at the urology centre, people might be sarcastic also and say the urology nurse came!!, I think who accepts to work as a nurse should be able to work at different specialties (G4-P2)	Acceptance to MHN (no stigma)	Positive
that's true, the stigma is related to nursing as a career but this matter will not stop me to choose MHN as a specialty (G4-P3)	The stigma of nursing career	
education is required to enable me to work as a MHN (G4-P2)	Need for mental health nursing education	

..I don't feel to have enough knowledge to work as MHN (G4-P2)	Need for mental health nursing education	
of course if we have a mentor in mental health this will make a huge difference, I will be able to see how she works, how she deals with different situations, (G4-P2)	Lack of role model in MHN	
, I believe clinical is much more important than theory....it will enable me to learn (G4-P1)	Need for mental health nursing education	
just we need someone who has the experience of mental health nursing to be with us (G4-P3)	Lack of role model in MHN	
we need a role model to follow (G4-P2)	Lack of role model in MHN	
I don't have any problems in my relationship with doctors...but worried about relationship with patients....it's one of my sources of fear and worry (G4-P1)	Professional therapeutic relationship	
I believe if we are educated well...we will be able to observe the patient and assess any risk factors (G4-P2)	Need for mental health nursing education	
yes, we need clinical training because theory doesn't tell us what to see and when to feel the patient is in a danger (G4-P3)	Need for mental health clinical training	
yes if I'm well trained , I will be able to prevent any harm for the patient (G4-P1)	Need for mental health clinical training	
Operation nurse is the most important in all nursing branches (G4-P1)	The hierarchy of nursing specialty preferences	
Operation nurse is more appreciated than MHN (G4-P2)	The hierarchy of nursing specialty preferences	
Operation nurse and ICU nursing are the most appreciated branches (G4-P3)	The hierarchy of nursing specialty preferences	
patients in the ICU needs nurses more than mental patients in the ICU, the patient might die, he is in real danger	The hierarchy of nursing specialty preferences	

and I have a role (G4-P1)		
but also mental health nursing is one of the worst ever, patient might kill you there (G4-P1)	Stigma: mental patients potentially violence	
I don't agree that MHN is the worst specialty...there is a risk within all nursing duties...(G4-P2)	Perception to nursing career	
Psychiatric illness is not infectious but if the patient is depressed I might get depressed also.. (G4-P1)	Stigma of working with mental patients	
if electro convulsive therapy is useful for the patient.Why not...if it will help (G4-P2)	Perception to ECT	
he is saying electricity...come on...do you agree to participate in this...for me I don't agree (G4-P1)	Stigma of ECT	
in fact we don't have enough knowledge about it ...we don't know if it is useful or it is harmful....it is electricity! (G4-P3)	Lack of knowledge about ECT	34 sentence
Group 5- four students- 4 students		

MHN is important field ...very important for many patients (G5-P1)	Valuing mental health nursing	
MHN is not a good branch for nurses (G5-P2)	Rejecting mental health nursing	
MHN is not a good branch..., not preferred to nurses (G5-P4)	Rejecting mental health nursing	
it will be useful even for my life, will give me experience to help many people (G5-P1)	Valuing mental health nursing	
I want to help mental patients, I can see that people call them mad and insane and the society stigmatize them, (G5-P3)	The stigma of mental illness in Egypt	
very negative, (G5-P3)	Rejecting mental health nursing	
Nurses become in danger if they worked in this field...and susceptible violence (G5-P2)	Stigma: mental patients potentially violence	
yes that's true many risks exist when working as a psychiatric nurse (G5-P4)	Stigma: mental patients potentially violence	
I think there is no shame in mental problems , shouldn't be a stigma (G5-P1)	Advocacy for mental patients	
MHN we are susceptible to risks of verbal or physical abuse,...(G5-P 2,4)	Stigma: mental patients potentially violence	
Yes all branches of nursing might include risks, yet risks at mental health are more and dangerous (G5-P 2,3,4)	Stigma: mental patients potentially violence	
Maybe ..if the doctor explained to me how to deal and communicate with patients ...the situation will be different and better ... this happen in private hospitals not the governmental ones (G5-P1)	Need for mental health nursing education	
I might think to work at MHN at private hospitals not governmental (G5-P3)	The effect of socioeconomic condition on psychiatric hospitals	
Psychiatric private hospitals have more facilities to serve the patients while this is not happening at governmental psychiatric hospitals (G5-P4)	The effect of socioeconomic condition on psychiatric hospitals	
Nurses at Private psychiatric hospitals have lower workload than governmental psychiatric hospitals.....private psychiatric hospitals are better places yet extremely expensive (G5-P2)	The effect of socioeconomic condition on psychiatric hospitals	
Although we are about to graduate after few days...I don't believe we had enough education that qualify us to	Need for mental health nursing education	

work at MHN...I will lack confidence to work at this field (G5-P4)		
The theoretical part about MHN was superficial and it was taught by a medical doctor not a nurse ..we didn't have clinical training at this field as well (G5-P3)	Lack of clinical training in MHN	
Psychiatric nursing is difficult...the patient's chances to cure is limited....I mean if I worked with a comatose patient at the ICU he will wake up or die but for mental patient ;prognosis is limited (G5-P4)	Negative view to psychiatric patients (Rejection)	18 sentence
Group 6 – 5 participants		

MHN is a good branch of nursing where it serve many patients (G6-P1)	Valuing mental health nursing	
In MHN we are able to help many people and prevent risks such as suicide and aggression, MHN is very important (G6-P2)	Valuing mental health nursing	
I have a different opinion....when I went to the psychiatric clinical placement I worked at the addiction department and found many nurses who become addict.. they used to take addictive drugs to work more hours and they end up at the psychiatric department...I felt I might be like them ,,so decided not to go again there (G6-P3)	Risk of addiction in the field of MHN	
Yes, many psychiatric nurses take addictive drugs that is available with them...just as a trial...but they didn't control the situation after that...it's scary situation (G6-P4)	Risk of addiction in the field of MHN	
I witnessed 3 psychiatric nurses who become addict and don't want to enter this field (G6-P5)	Risk of addiction in the field of MHN	
I know that MHN has many positive sides yet, we are susceptible to risks as assault verbally and physically, unfortunately can not choose it as a career choice (G6-P3)	Stigma: mental patients potentially violence	
I imagined my self locked inside like the patients and insulted by each one in the department....i hated the whole situation...the practice I saw from nurses at mental health was unacceptable (G6-P3)	Organizational culture	
Sometimes the workload on psychiatric nurses is huge (G6-P5)	Expectations regarding workload in MHN	
I don't like to be part of this nursing , I mean MHN..., I didn't find a role model to follow in psychiatry (G6-P2)	Need for role modeling in MHN	
For me the situation is different, I liked working at MHN, it's very good branch (G6-P1)	Valuing mental health nursing	
I found some doctors who explain to us the different diagnosis and support us at many situation (G6-P1)	Team working support at MHN	
We will graduate after one	Lack of clinical training in MHN	

month and many of us didn't have any clinical training or supervision at mental health (G6-P2)		
If we had clinical training ...I mean with supervision from the school teachers...the situation will be different (G6-P5)	Lack of clinical training in MHN	
I'm not sure that I understand the professional relationship with mental patients...sometimes I felt that patients consider us their family & friends...yet this is not true,,, This issue put psychological burden on us (G6-P4)	Professional boundaries with mental patients: the therapeutic relationship	
In theory we were told to build relationship with patients , but in clinical I found the application of this really difficult (G6-P3)	Professional boundaries with mental patients: the therapeutic relationship	
I was taught signs and symptoms of mania, schizophrenia but didn't know how to communicate and care for them (G6-P1)	Need for mental health education	
After I saw psychiatric nurses, I decided not to work at this field (G6-P3)	Lacking role modeling in MHN	
MHN is a psychological burden for me (G6-P2)	Rejection of MHN	
Private psychiatric hospitals are better than governmental but it is very expensive ... (G6-P1)	The effect of socioeconomic state on MHN	
Private psychiatric hospitals will take care of patients and consider that workload on nurses, patients at private hospitals are valued and well treated because their families usually follow up with the hospital and pay a lot of money, this is opposite to governmental hospitals (G6-P5)	The effect of socioeconomic state on MHN	
I noticed my self scream and shout at patients like nurses in the department when I worked at psychiatry....didn't like my behavior ...I just copied what other nurses do and thought this is the only way of communication there (G6-P4)	Need for role model in MHN	21 sentence
Group 7 - 5 students		

Our role is positive and important with patients, we play an important part of the patients' progress (G7-P1)	Valuing mental health nursing	
I like working with mental patients because sometimes they can't express what they feel or need, they don't have voice at many situations, I feel that I must help them (G7-P2)	Advocacy for psychiatric patients	
I attended many sessions for activities with mental patients and found that we positively influence their psychological condition, it is a positive field to work at (G7-P3)	Valuing mental health nursing	
But our study depended on theoretical part without any clinical training in mental health... this decreases my confidence to work at this field (G7-P4)	Lack of clinical training in mental health nursing	
People in the society say patients in psychiatric facilities are mad ...yet I believe calling them mad decrease any chance of providing help and support to them.. they are patients like any other patient (G7-P2)	Stigma of mental illness in Egypt	
...yes, the society see any patient who seek medical advice related to psychiatric problem to be mad... this is shameful (G7-P5)	Stigma of mental illness in Egypt	
The Egyptian society categorize nursing career with the disrespected careers, they stigmatize nursing as a career not only psychiatric nursing (G7-P5)	Stigma of the nursing career	
Yes, I agree...nursing is not a job with a good reputation...I wish the nursing image improves in Egypt (G7-P4)	Stigma of the nursing career	
Nursing has its problems but I think the place of work make a difference, in mental health private hospitals are much better than governmental psychiatric facilities, regarding patient respect and human rights and all facilities (G7-P2)	The socioeconomic effect on mental health	
I don't agree about the issue of private hospitals are better, I worked at a governmental psychiatric hospital and nurses	The humanistic role of MHN	

were very kind to patients (G7-P1)		
One of my fears is the patient and his behavior ...sometimes they are unexpected (G7-P3)	Stigma: mental patients potentially violence	
MHN could be better a male job (G7- P2,P4, P3)	Gender and MHN	
Locking patient inside all the time make me feel helpless and sad for them..... they deserve better treatment (G7-P4)	The humanistic role of MHN	
I worked at a psychiatric hospital for 9 months and liked the experience, yet sometimes the patient become aggressive to the extent that he can harm himself or the medical team.. it's scary sometimes (G7-P1)	Stigma: mental patients potentially violence	
..what reassures me is the teamwork...I trust the team I work with and I know that I'm not left alone with patients...the team can observe very well if aggressive situation happened and they interfere quickly to protect both patient and staff (G7-P1)	The effect of team working on MHN	
One of the challenges is that theory is separated from practice regarding psychiatric nursing, education needs to be developed for this specialty (G7-P3)	Need for mental health nursing education	
Sometimes the people call psychiatric nurses "nurses of mad people" in Arabic "Al Majaneen" but I don't take it seriously, (G7-P3)	The stigma of psychiatric illness in Egypt	
I think my role is to take care of the patient and their safety, aslo to teach them what is right and what is wrong (G7-P2)	The moral role of MHN beyond professional practice	
....I might advice a patient about her behavior if I knew she has relationships and male friends (G7-P2)	The moral role of MHN beyond professional practice	
I feel sometimes the patients are aware of what they do....i worked in the addiction department before and was beaten by a patient there....i didn't go there again (G7-P4)	Stigma: mental patients potentially violence	
...for example I will tell the patient to go to pray...or let him listen to the quran...I will do this if I found a patient who is not	The moral role of MHN beyond professional practice	

praying (G7-P5)		
I will tell him to pray so God relief his illness, he might be convinced (G7-P5)	The moral role of MHN beyond professional practice	22 sentence
Group 8- 4 participants		

MHN is a challenge as a career choice...before one decides to work at this field I think...a period of training will be required to check if I can work at this field or not (G8-P1)	Lack of clinical training in MHN	
I'm not sure if MHN would suit my personality...I don't have any experience or training before (G8-P1)	Rejection of mental health nursing	
Nurses are extremely important in the field of mental health....we spend long time with patients (G8-P2)	Valuing mental health nursing	
MHN requires some special personal qualities to be able to communicate with patients and I wish to work at this field (G8-P3)	Motivation to work at mental health nursing	
MHN requires humanistic way to treat patients (G8-P3)	The humanistic role of MHN	
Knowledge is the key for success in MHN... nurse should be aware of different diagnosis and how to communicate with each patient (G8-P4)	Education and mental health nursing	
I can't...can't work as MHN...it is not for me (G8-P4)	Rejection of MHN	
I'm not sure if the patient will respond to treatment....or will be able to communicate with me...(G8-P4)	Lacking confidence to work at MHN	
I don't have a clear idea of what should be my role as MHN...didn't have clinical training or experience at this field before (G8-P2)	Role of MHN and lack of clinical training	
Patience, good communication skills and ability to observe and assess are main qualities for MHN (G8-P1)	Qualities to work as MHN	
I had experience to work at MHN before, wish to work in MHN again (G8-P1)	Motivated to work at MHN	
I witnessed cruel nursing practice, nurses at mental health are aggressive sometimes and angry...I want to work at this field to communicate with patients in a more humanistic way (G8-P1)	Staff cruelty with mental patients	
I saw many nurses threaten the patients with isolation, ECT, and other methods...they think this is the way to control the patients ...I don't agree (G8-P1)	Staff cruelty with mental patients	

..also seclusion and using restraints were used frequently...I didn't feel comfortable with such practice...there are always alternatives (G8-P3)	Staff cruelty with mental patients	
When I worked at mental health..i found some patients are aggressive verbally... they look angry most of the time and I was afraid from them (G8-P3)	Stigma: mental patients potentially violence	
Nurses used to restrict patient's freedom and this reflects negatively on patients....(G8-P3)	Staff cruelty with mental patients	
Usually the society describe anyone who suffer from a psychiatric problem as mad, this is a stigma to the person and his whole family (G8-P4)	Stigma of psychiatric illness in Egypt	
People say that mental health nurses are psychologically disturbed as well (G8-P4)	Stigma of working at MHN	
'I agree.. the society do stigmatize patients and nurses and usually see MHN as depressed or disturbed (G8-P2)''	Stigma of working at MHN	
Also many people advice patients to stay away from psychiatric doctors... it's a stigma to go to a psychiatric doctors (G8-P1)	Stigma of seeking psychiatric medical help	
Going to psychiatric doctor and seeking help is very stigmatizing and people say this will bring more disturbance...they prefer ignoring the problem than acknowledging it (G8-P2)	Stigma of seeking psychiatric medical help	
Yes..i saw many people when they see a person suffering from depression ..they advice not to go to a doctor... this is the last option to avoid stigma (G8-P3)	Stigma of seeking psychiatric medical help	
My family think MHN is a dangerous specialty and they don't agree to work at it... they believe patients are risky and this specialty is stigmatizing (G8-P1)	Stigma: mental patients potentially violence	
May family have the same opinion about MHN... it's dangerous and stigmatizing (G8-P2)	Stigma: mental patients potentially violence	
Other specialties such as internal medicine and pediatric	The hierarchy of nursing specialty preferences	

are more easier for nurses than MHN (G8-P4)		
I think nurses should be able to work in all specialties..... including MHN.. we might meet psychiatric patients at many places in our life or at general hospitals as well (G8-P1)	Valuing mental health nursing	
Part of my role is to take care of the patients and observe their behavior	The moral role of MHN beyond professional practice	
And if I found a patient who is not praying, I will advice him to pray and remind him with the time of calling to pray .. (G8-P2)		
Yes I can also invite other patients to pray then he will join us when he see them praying... praying is a must every day (G8-P3)	The moral role of MHN beyond professional practice	29 sentence

Appendix 9

Codes from Data analysis

Research question: What is the perception of MHN among student nurses, Cairo university

Theme one (The Stigma)

1. Stigma: mental patients potentially violence
2. **Stigma**: fear of patients
3. **Stigma** of mental health nursing, disabling nature of mental illness
4. Stigma of working with mental patients/ rejection of mental patients
5. Stigma: fear of mental patients violence potential behavior/ Fear of responsibility as MHN
6. Stigma of ECT and aggressive behavior of MHN
7. Stigma of working as a nurse
8. Stigma of seeking psychiatric medical help
9. Stigma of mental illness in the Egyptian community
10. Stigma of seeking psychiatric medical help
11. ECT stigma
12. Stigma of working as MHN
13. Unconcerned about stigma
14. Staff cruelty with mental patients
15. The role of media of stigmatizing ECT
16. Role of media in degrading MHN

Theme 2 - MHN as a career choice:

17. Motivated to work at MHN
18. Negative view to psychiatric patients (rejection- prefer not to work as MHN)
19. Choosing MHN as a career choice
20. The hierarchy of nursing specialty preferences
21. Low chances of employability in MHN
22. Lack of motivation to work at MHN

- 23. Hesitancy prior to choosing MHN as a career
- 24. Rejection of MHN
- 25. Team working support at MHN
- 26. The importance of psychiatrists

Theme three (Role of Mental Health Nurse)

- 27. Humanistic role of nursing
- 28. Valuing mental health nursing
- 29. Qualities to work as MHN
- 30. Difference between medical specialties and psychiatric nursing
- 31. Lack of recognition of mental health nursing
- 32. Expectations about low workload
- 33. Lacking trust of mental health nurses
- 34. Lack of advocacy role of MHN
- 35. Professional boundaries with mental patients: the therapeutic relationship
- 36. The negative attitude of MHN
- 37. The moral role of MHN beyond professional practice
- 38. The professional role of MHN
- 39. Lack of confidence to work as MHN

Theme 4- the challenges associated with MHN

- 40. Communication barrier with patients with mental illness
- 41. Nonverbal communication/ communication barrier
- 42. Gender issue: MHN is a male job
- 43. Need for clinical training;
- 44. Lack of knowledge about the role of MHN
- 45. The need for enhancing MHN education
- 46. Lack of clinical training as MHN
- 47. Need for clinical supervision
- 48. Lack of knowledge about ECT
- 49. Lack of MHN role model
- 50. The effect of socioeconomic condition on psychiatric hospitals
- 51. Risk of addiction in the field of MHN
- 52. Expectations regarding workload in MHN

Final themes and subthemes emerged from the study

Theme one: Stigma and Mental Health Nursing

Sub-theme (1)- Fear and the concept of stigma among student nurses

Sub-Theme (2)- Stigma and organisational behaviour of mental health professional carers

Sub-theme (3)- Stigma and the influence of culture

Theme two- The Challenge of lack of a structured curriculum for mental health nursing

Subtheme (1) Training deficiency and distorted perceptions of MHN

Subtheme (2) ECT as a factor influencing perceptions of MHN

Sub-theme (3) Lack of communication skills